

**Developing Smoking Cessation Services in  
Primary Care: A Case Study of one Scottish  
Health Board**

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2005



**Dedicated to:**

My parents



## **Declaration**

I declare that this Thesis:

- (a) Has been composed by myself
- (b) Is my own work
- (c) Has not been submitted for any other degree or professional qualification except as specified

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## Abstract

**Aim:** The White Paper Smoking Kills advocated the development of NHS smoking cessation services as a strategy for reducing smoking prevalence in the UK. Each Scottish Health Board has undertaken responsibility to develop local services since 1999/2000. The aim of this PhD research was to investigate the factors involved in, and issues around, the development, delivery, evaluation and sustainability of these services in one Scottish Health Board area.

**Method:** Semi-structured interviews were held with 34 key stakeholders involved in the development, delivery and evaluation of the smoking cessation services within one Health Board area in Scotland. This involved interviews with Health Board staff, members of the Advisory Group for the Health Board's Tobacco White Paper programme, and key stakeholders within 7 of the 8 LHCCs (or LHCC equivalents) within the Health Board, who were involved in the development and delivery of local services. Interviews were transcribed verbatim and analysed for key themes using a Grounded Theory approach.

**Key Results:** **1.** Local service development relied heavily on the interest, enthusiasm and commitment of several key staff members, who acted to drive local services forward. There were clear issues around professional roles and boundaries, and the perception of smoking cessation as a core work activity and priority within the workload. GPs were perceived to be ambivalent about their smoking cessation role, and there were reported inefficiencies in brief interventions provided by this profession. **2.** Zyban was widely perceived to be a key catalyst in the development of services within primary care. LHCCs developed different services, ranging from practice-based services, LHCC-based services offering centralised support, to a combination of practice-based and centralised LHCC-based support. Local prioritisation of smoking cessation/tobacco issues, and the development of a co-ordination strategy, were two key factors identified as facilitating local service development and delivery. **3.** There was a perceived lack of funding and prioritisation of services by The Scottish Executive. This was described as impacting upon the priority assigned to smoking cessation locally, and the ability of LHCCs to develop comprehensive and sustainable services. The Health Board monitoring/evaluation of local smoking cessation services was commonly perceived to be inadequate for reflecting the work that was put in 'on the ground', and for providing LHCC staff with reliable data with which to inform service development/delivery. **4.** Lack of

progress in developing services to target the three priority groups (young people; pregnant women; low-income) was underpinned by perceptions of the suitability and capacity of primary care. Additionally, staff operated within different ethical/theoretical frameworks, which informed the development/delivery of local services.

**Conclusion:** This research found that smoking cessation experienced difficulties commonly associated with the implementation of health promotion practice within the primary care setting. The research has also shown that it is crucial to account for perceptions around the suitability and capacity of the settings within which health promotion strategies are implemented, and the ethical/theoretical frameworks informing the interventions offered by service providers. Many of the difficulties experienced in developing services were attributed to a perceived lack of funding, and priority assigned to smoking cessation nationally. However, there has been an increased political priority and financial commitment to the NHS smoking cessation strategy since the fieldwork was carried out, the potential implications of which are discussed in the thesis.

**Implications for Practice, Policy and Research:** This research provides the first in-depth analysis of smoking cessation service development in Scotland. In doing so, it has highlighted some of the key issues associated with the development and delivery of sustainable smoking cessation services, particularly within the primary care setting. It lends support to many of the recent policy initiatives and recommendations that have witnessed an increased financial commitment to the development of the NHS smoking cessation strategy, and potentially improved co-ordination/management and monitoring of Scottish services. Additionally, it recommends that future smoking cessation strategies should account for the setting in which they are to be implemented, the ethical/theoretical frameworks informing service provision within these settings, and where smoking cessation is perceived to sit within 'core' work duties. Future research should investigate the impact of increased funding, and the potentially more efficient monitoring and co-ordination of services on smoking cessation service development in Scotland. Further research should also be conducted with GPs to establish ways in which they can be more effectively engaged in providing smoking cessation interventions.

## Acknowledgements

**I would like to acknowledge and thank the following people for their support in the process of conducting this research:**

The Chief Scientist Office (CSO) at The Scottish Executive, who funded this PhD as part of their Health Services Research Studentship Programme.

My PhD supervisors, Dr Amanda Amos and Professor Odette Parry, for their professional guidance and encouragement. They provided me with a fantastic level of support from start to finish, for which I am very grateful.

My research participants, who gave their time to be interviewed, without which completion of this PhD would not have been possible.

My family, and especially my parents, for supporting and encouraging me throughout.

Mark Cummings, for taking the time to proof-read my final draft and for supporting me through the final days!

My friends, and my PhD peers, whose friendship and encouragement made completing this PhD a much less lonely process.

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# CHAPTER ONE

## Introduction

The White Paper '*Smoking Kills*' (Department of Health, 1998a), was the first ever White Paper on tobacco in Britain. It demonstrated an effort by the government to place tobacco issues high on the political agenda, and to take positive, directive action in an attempt to reduce smoking prevalence in the UK.

This thesis is grounded in one of the key policy and practice implications of *Smoking Kills*. However, before going on to discuss the details of this White Paper, it is crucial to locate its place and importance within the wider UK public health and health service context.

### 1.1. Setting the scene

This introduction provides a background to the literature review (Chapter two). It focuses on three key areas, which act to place the *Smoking Kills* White Paper in a health policy context. These three areas are: (a) health promotion and UK health policy; (b) smoking, ill-health and health inequalities; and (c) health promotion, primary care and smoking cessation. Discussion of these issues is followed by an outline of the aims of this PhD and its key research questions.

#### 1.1.1. Health promotion and UK health policy

The principles of health promotion have become increasingly embedded within health policy in the UK. It is important, however, to begin by defining 'health promotion' as it is a widely used term, and can assume different meaning for individuals. This is largely a consequence of the plethora of activities that can fall within such a broad working concept. When reflecting upon the definition of health promotion, it is first of all important to consider its roots in the field of *health*

*education*. Health education traditionally placed a heavy emphasis on individual responsibility for health. That is it tended to use behavioural approaches to addressing health problems through education, to essentially tackle individual behaviours/lifestyles and prevent ill health. Health education efforts and interventions have therefore been strongly associated with disease/illness *prevention*, and often targeted at those groups within the population at greatest risk (Naidoo & Wills, 2000). Health promotion has been described as being “*rooted in the narrower, and more established field of health education*” (Downie *et al.*, 1996, p.27). However, an emphasis simply on prevention, and the expectation of a direct link between education/intervention and behaviour change, has been criticised for neglecting the wider influences on health (Downie *et al.*, 1996).

Beyond education and individual behaviour change, *health promotion* has come to encompass a much broader view of health, in terms of influences upon health, and interventions to promote health. The *social change* approach to health promotion, for instance, focuses on changes at the structural social/political/environmental level that may impact upon health. The public health movement of the twentieth century played a key role in the development of this broader model of health promotion (Naidoo & Wills, 2000; Bunton & McDonald, 1992), specifically by highlighting the wider environmental influences upon health. The definition of health promotion as “*the process of enabling people to increase control over, and to improve, their health*” (WHO, 1986), is one that is commonly drawn upon. Essentially, health promotion can be viewed as an ‘umbrella’ term that encompasses all interventions that are designed to promote health. The following quote expands upon the Ottawa Charter definition, and offers a useful working definition of health promotion, and the role of health education within it:

*“The terms health promotion and health education are not interchangeable. Health promotion covers all aspects of those activities which seek to improve the health status of individuals and communities. It therefore includes both health education and all attempts to produce environmental and legislative change conducive to good health. Put another way, health promotion is concerned with making healthier choices easier choices”.* (Dennis *et al.*, 1982)

Health promotion has, therefore, come to be viewed as a broader concept for describing a range of interventions designed to improve and facilitate health and well-being, including health education, and strategies to tackle the wider structural influences on health.

In terms of the health promotion approaches adopted within UK health policy, it is clear that there has been a significant shift over the past three decades. A Department of Health document in 1976- '*Prevention and Health: Everybody's Business*' clearly placed much of the emphasis for health improvement on individual behaviour change:

*"To a large extent though, it is clear that the weight of responsibility for his own health lies on the shoulders of the individual himself. The smoking-related diseases, alcoholism and other drug dependencies, obesity and its consequences, and the sexually transmitted diseases are among the preventable problems of our time and, in relation to all of these, the individual must decide for himself"* (DHSS, 1976).

This 'individualistic' view was again re-iterated in 1987, in the UK government White Paper "Promoting Better Health" (Department of Health, 1987). Indeed, major health campaigns of this time, such as those tackling AIDS ("Don't die of ignorance") and coronary heart disease ("Look after your heart"), appeared to attribute much of the responsibility for achieving good health to the individual (Naidoo & Wills, 2000). Key government White Papers of the 1990's, however, clearly suggest that a much broader approach to health promotion has been adopted as a key health strategy for improving the nation's health. In particular, there has been an increasing emphasis on tackling both *lifestyles and life circumstances*.

The Health of the Nation (Department of Health, 1992) defined health improvement as being underpinned by *public policies* (consideration of the health impact of policies), *healthy surroundings* (creating environments that facilitate health), *healthy lifestyles* (e.g. tackling smoking), and *high quality health services*. The political focus on tackling health inequalities has been particularly prominent since the election of the New Labour Government in 1997. This focus on health inequalities has

facilitated concentration on a wider health promotion approach to improving the nation's health. Consequently, key White Papers for health in the UK have been underpinned by the overarching aim to reduce inequalities in health, with an emphasis on tackling both lifestyles (e.g. smoking; alcohol; physical activity) *and* life circumstances (e.g. housing; education; employment) (The Scottish Office, 1999a; Department of Health, 1999a). In terms of *lifestyles*, smoking has been highlighted as one key lifestyle factor to be targeted through health promotion. As discussed in the following section, smoking is recognised as being the most significant lifestyle factor contributing to inequalities in health, and has therefore increasingly become a key focus of UK health policy.

### **1.1.2. Smoking, ill-health and health inequalities**

Inequalities in health in the UK are well documented. The Black Report (Department of Health & Social Security, 1980), represented a significant milestone in the health inequalities debate in the UK, whereby the difference in health status between social groups was markedly documented. One of the key findings of the Black Report was that for both males and females in the UK, and across all age groups, there were notable differences in mortality rates between the occupational groups, from 'unskilled manual' groups (Class V) to 'professional' groups (Class I). An updated in-depth analysis on the evidence surrounding health inequalities was commissioned by the Health Education Council in 1986, culminating in the publication of 'The Health Divide' (Whitehead, 1988). This report confirmed the overall premise of the Black Report, indicating that:

*"...serious social inequalities in health persisted throughout the 1980s. Whether social position is measured by occupational class, or by assets such as house and car ownership, or by employment status, a similar picture emerges. Those at the bottom of the social scale have much higher death rates than those at the top. This applies at every stage of life from birth through to adulthood and well into old age" (Townsend et al., 1992, p.394).*

A more recent independent inquiry into inequalities in health (Acheson, 1998) again indicated that inequalities in health (and also in determinants of health) were

demonstrable according to socio-economic groupings, in addition to ethnicity and gender.

Smoking contributes to over 120,000 deaths per annum in the UK, accounting for one in five deaths (Callum, 1998). The Department of Health has estimated that avoiding smoking would eliminate one third of all cancer deaths, and one sixth of deaths from other causes (Department of Health, 1998b). Given that smoking prevalence is higher amongst lower socio-economic groups (National Statistics, 2004), it is not surprising that the *Smoking Kills* White Paper (Department of Health, 1998a) identified smoking as the most significant lifestyle factor contributing to the socio-economic gap in life expectancy in the UK. Indeed, a correlation between class trends in deaths from two major illnesses, and smoking trends has been observed:

*“Class trends in mortality from lung cancer and coronary heart disease show some similarity to the smoking trends [...] Mortality from lung cancer and coronary heart disease is higher in the unemployed than in the employed population, and regional variations in mortality from the diseases mirror the smoking variations to a certain extent”* (Townsend *et al.*, 1992, p.317).

The most recent General Household Survey results indicate that 26% of the adult population in the UK smoke (National Statistics, 2004). This figure is higher in Scotland, at 28% (National Statistics, 2004) with 35% of men aged 25-34 smoking, and 31% of women aged 16-44 smoking in Scotland (The Scottish Executive, 2005). These recent General Household Survey figures reflect previous (Department of Health, 1998b) reported socio-economic trends in smoking prevalence. Specifically, smoking prevalence in the UK is shown to be higher amongst ‘routine and manual groups (33% male, 31% female) than ‘managerial and professional’ groups (19% men and women) (National Statistics, 2004). In Scotland, where smoking prevalence rates are higher, smoking prevalence amongst adults aged 16-64 in *deprived communities* has recently been reported at 42.1% (The Scottish Executive, 2004a).

Given the impact of smoking on ill-health, and the link between smoking and health inequalities, it is clear why smoking is one lifestyle factor that has gained increasing prominence in UK health policy. As will be discussed in the following section,



health promotion in the primary care setting has become a key health policy strategy for the *prevention* of ill-health within the UK population. Smoking cessation interventions have come to play a key part in this strategy.

### **1.1.3. Health promotion, primary care and smoking cessation**

The declaration of Alma Ata (WHO, 1978) highlighted the important role of primary health care (and health promotion) in the achievement of the Health for All 2000 (HFA 2000) strategy (Naidoo & Wills, 1998). Since the 1980s there has been a continuous push to strengthen the position of primary health care in the NHS. With the election of New Labour in 1997, primary care has been a central focus of the NHS in terms of the Government's strategic plans for change. The White Papers '*The New NHS: modern and dependable*' (Secretary of State for Health, 1997), and '*Designed to Care*' (Department of Health, 1997), outlined the strengthening of primary care through the creation of primary care groups (England) and primary care trusts (Scotland). Primary care groups and primary care trusts would have responsibility (financially and strategically) for providing primary health care services to meet the needs of local populations.

In addition to the strengthening position of primary care, increasingly efforts have been made to incorporate the principles of health promotion into primary health care practice. Given that patient contact in primary care constitutes most (approximately 90%) of all patient contact with the NHS (Mant, 1997), the potential impact that primary health care professionals can have on the prevention of ill health in the general population is enormous. General Practice in particular has long been recognised as a crucial location for the provision of health education, and the potential to influence health behaviours (Fowler, 1986; Fowler, 1985).

The *prevention* model of health promotion has been described as being particularly favoured by the government, given the focus it places on individual responsibility, and the economic impact of deaths from major (largely) preventable illnesses, such as coronary heart disease and stroke (Williams *et al*, 1993). GPs in particular are well placed to lead initiatives towards the 'prevention' of ill-health (Allsop, 1995), given



their access to patients. Since the 1990's, there have been increased efforts to integrate health promotion practice into primary care and, more specifically, within General Practice. This has been signalled by the introduction in the 1990s of three contractual arrangements with GPs in order to encourage the development of health promotion services within general practice (Department of Health and the Welsh Office, 1989; FHSL, 1993; FHSL, 1996). Each of the GP contracts centred around financial incentives for the development of health promotion services, and acted to encourage a model of illness *prevention*, as opposed to just a curative approach.

With regards to smoking, the impact of health education within General Practice on smoking cessation was documented as early as 1979, in seminal research by Russell et al (1979). Russell et al's research constituted a rigorous randomised control trial, which found that anti-smoking advice had a significant impact on quit rates compared to controls. The GP contracts of the 1990's facilitated the potential for development of smoking cessation strategies within General Practice. The 1990 Contract in particular (Department of Health and the Welsh Office, 1989), offered financial incentives for the development of smoking cessation interventions (Raw *et al.*, 1998a). The subsequent contracts in 1993 (FHSL, 1993) and 1996 (FHSL, 1996) were less specific about smoking cessation however, and did not define it as an obligatory health promotion activity (McEwan & West, 2001).

Although the GP contracts of the 1990s facilitated the development of health promotion interventions within primary care, there was a lack of knowledge around the extent to which smoking cessation interventions had been fully integrated into routine practice within the General Practice setting (McEwan & West, 2001; Raw *et al.*, 1998a). The requirement for a national strategy to facilitate the integration of smoking cessation within primary care was therefore advocated (Raw *et al.*, 1998a). This leads onto the role of the *Smoking Kills* White Paper (Department of Health, 1998a), which set out plans for the development of a national NHS smoking cessation strategy. This strategy will be discussed in the following section, along with the focus and aims of the Thesis.

## 1.2. Focus and aims of the Thesis

The publication of the White Paper 'Smoking Kills' in 1998 was a significant turning point in the priority assigned to tackling smoking by the UK Government, and the resources assigned to doing so. The White Paper set out a comprehensive tobacco control strategy, which aimed to reduce smoking in both young people and adults. One of the key elements of this strategy was the development of local NHS cessation services, which aimed to provide smokers who wanted to quit with appropriate advice and support. The provision of brief advice and follow-up in *primary care* was identified as underpinning the NHS smoking cessation strategy. The White Paper committed ring-fenced funding to the development of these services for three years (£3 million in Scotland for 1999-2002). In addition, Smoking Kills highlighted three specific target groups for these services - young people, pregnant women, and low-income groups.

In Scotland, Health Boards were charged with planning services around these priorities and producing local strategies to tackle smoking. In addition to brief advice and follow-up in primary care, guidelines stipulated that any smoker wishing to quit should be able to access smoking cessation support, with services tailored to meet their needs (Raw *et al.*, 1998a; ASH Scotland and HEBS, 2000). A range of support would be on offer, from brief interventions to more intensive smoking cessation support services (approximately 6 weeks of group/one-to-one support from a trained health professional). The provision of pharmacological support (NRT and Zyban) constituted a key part of this strategy.

The UK was, and remains, unique in the world in attempting to establish comprehensive free local smoking cessation services. The development and delivery of these services thus created enormous challenges as well as opportunities for primary care. For while it has long been recognised that GPs and other members of the primary care team can play an important role in helping their patients give up smoking, this had tended to be approached in a rather ad hoc, opportunistic way.

The development of these new smoking cessation services provided a unique opportunity to undertake an in-depth analysis of the processes that contribute to and/or hinder the development, delivery, evaluation and sustainability of health promotion in primary care. The aim of this PhD study, therefore, is to investigate issues around the development, delivery, evaluation, and sustainability of the smoking cessation services within one Scottish Health Board. The research takes the form of a case study, involving qualitative interviews with key informants in one Health Board in 2002/3, most of whom were involved in the development and delivery of services at the LHCC level. LHCCs (Local Health Care Co-operatives) provide primary care services within defined geographical areas of a Health Board. The ultimate aim of the PhD is to be able to draw lessons from this Health Board's experience, which could be applied to the future development of smoking cessation services in primary care in Scotland.

### **Research Questions**

1. What smoking cessation services have been developed and delivered by each of the LHCCs (or LHCC equivalents) within the Health Board?
2. What are participants' perceptions of the factors that have influenced the development, delivery, and evaluation of the smoking cessation services within each LHCC (or LHCC equivalent)?
3. What are participants' perceptions of the issues around the evaluation of the smoking cessation services?
4. What are the implications for the long-term sustainability of these services?

# CHAPTER TWO

## Literature Review

This literature review has six main sections. Section one introduces the *Smoking Kills* White Paper, whilst the second and third sections discuss the guidelines and governmental input/guidance that have supported the implementation of the NHS smoking cessation strategy. Section four then outlines the key findings from the English evaluation of smoking cessation services, which was ongoing at the time I conducted my research. As yet, there has been no similar comprehensive research conducted on smoking cessation services in Scotland. The majority of the findings from the English evaluation research, however, were not published until 2005, and therefore publications were limited at the time I conducted my research. However, the key research findings regarding service development in England are pertinent to the focus of this thesis. The fifth and sixth sections of the literature review discuss two areas of literature that broadly underpin the focus of this thesis. These literature areas are (a) health promotion in primary care, and (b) policy and guideline implementation in the health service.

### **2. 1. *Smoking Kills*: The White Paper**

*Smoking Kills* (Department of Health, 1998a) set out the Government's first comprehensive strategy to tackle tobacco issues and reduce smoking prevalence within the UK. The White Paper drew on the evidence of UK smoking trends. This demonstrated that at the time of the White Paper, the downward trend in smoking prevalence had not only stabilised, but had in fact started to reverse since 1994. Specifically, the 1996 General Household Survey suggested that smoking prevalence had increased since 1994, from 26% to 28% of the population in England aged 16 years and over (Office for National Statistics, 1998).

In Scotland, the smoking prevalence rate was found to be higher than that in England, at 32% (Office for National Statistics, 1998). Since 1988, there had also

been an upward trend in smoking prevalence in the under 16 age-bracket, to the extent that in 1996, 13% of young people in England aged 11-15 years were found to be regular smokers, compared to a reported 8% in 1988 (Office for National Statistics, 1998). As approximately 80% of smokers start smoking in their teenage years (Coleman, 2004), and given the reported rise in smoking amongst young people, targeting this groups of smokers for cessation efforts is particularly important.

The White Paper also highlighted smoking and pregnancy as an area of concern, particularly given the adverse health effects on the unborn child. Smoking in pregnancy has been shown to be more prevalent amongst younger women (aged 15-24 years) and particularly so amongst lower socio-economic groups. Around 45% of pregnant women smoke in low-income groups, as opposed to 8% in professional and non-manual groups (Owen *et al.*, 1998), thereby reflecting the wider socio-economic pattern of smoking prevalence. Helping women to quit smoking whilst pregnant offers a valuable opportunity to help these smokers quit in the longer term. It is also opportune given that many women consider changing their health-related behaviour during pregnancy (Royal College of Physicians, 2000; Coleman 2004).

*Smoking Kills* therefore advocated targeting smoking reduction strategies at three groups in particular: young people under the age of sixteen that smoked; all adults, but with a particular emphasis on disadvantaged groups (within the framework of reducing health inequalities, as outlined in chapter 1); and pregnant women. These specific populations were highlighted in line with the following targets for England:

- to reduce smoking amongst those under the age of sixteen from 13% to 9% or less by 2010 (11% by 2005)
- to reduce adult smoking in all social classes from 28% to 24% or less by 2010 (26% by 2005)<sup>1</sup>
- to reduce smoking amongst pregnant women from 23% to 15% or less by 2010 (18% by 2005)

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<sup>1</sup> In an effort to address the socio-economic gap in smoking prevalence and ill-health, The NHS Cancer Plan (Department of Health, 2000b) also set targets for *manual* groups (to reduce smoking rates from 32% in 1998 to 26% by 2010).

These targets were set according to the smoking prevalence rates in England, as outlined above. However, in a White Paper for Health, (The Scottish Office, 1999a), specific smoking targets were set for Scotland for these three groups, which took into account the higher Scottish smoking prevalence. The targets set for 2010 were reiterated in 2002 (The Scottish Executive, 2002a). These targets were as follows:

- to reduce smoking amongst young people from 14% to 12% between 1995 and 2005 (11% by 2010)
- to reduce adult smoking rates from an average of 35% to 33% between 1995 and 2005 (31% by 2010) <sup>1</sup>
- to reduced prevalence of smoking amongst pregnant women from 29% to 23% between 1995 and 2005 (20% by 2010)

In an attempt to meet these targets, *Smoking Kills* identified the key political action that would be required. This included legislation to phase out tobacco advertising and sponsorship, a more substantially budgeted media campaign on tobacco, a drive against tobacco smuggling and greater international action against tobacco; ‘Clean Air’ initiatives; and action to discourage under-age sales (i.e. implementation of proof-of-age cards). Over and above these measures however, *Smoking Kills* laid out the Government’s plans to invest money into new NHS smoking cessation services in the UK. It was proposed that for a period of three years (1999-2002), £60 million in England, and £3 million in Scotland would be invested in such services. Such a national approach to smoking cessation, and the allocation of ring-fenced investment for these services, marked a new level of commitment by the UK Government in helping smokers to quit, and constituted the first of its kind in the UK.

Broadly speaking, the provision of smoking cessation advice by healthcare professionals, and pharmacological support, were identified as key to this strategy. Underpinning its implementation was the publication of structured and evidence-based guidelines. As outlined in *Smoking Kills*, the Health Education Authority was commissioned by the Government to develop such smoking cessation guidelines, and these were published in *Thorax* (Raw *et al.*, 1998a). The guidelines were based on

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<sup>1</sup> The Scottish Executive (The Scottish Executive, 2004a), reviewed these targets and reduced the target for smoking rates in adults to 29%. Targets were also set, for the first time, for low-income groups (reduction in smoking prevalence in adults aged 16-64 from 42.1% in 2003 to 37.5% in 2008).

the findings from systematic reviews conducted by the Cochrane Tobacco Addiction Review Group (Cochrane Library Reviews), the US Agency for Health Care Policy and Research (AHCPR), as well as evidence from the American Psychiatric Association. Additionally, the guidelines were extensively peer reviewed, and received wide endorsement from many professional organisations. These guidelines essentially provided the evidence-base behind the Government's smoking cessation strategy. Given some of the structural differences in the health care system between Scotland and England, separate smoking cessation guidelines were produced for Scotland in 2000 by the Health Education Board for Scotland and Scottish Action on Smoking and Health (HEBS & ASH Scotland, 2000)<sup>1</sup>. These guidelines however strongly reflected the recommendations set out in *Thorax*.

The implementation of the national smoking cessation strategy was informed by two key sources. These sources were (a) the smoking cessation guidelines, and (b) additional Government guidance (i.e. policy statements/guidance from the Department of Health, The Scottish Executive, and associated governmental bodies). Both sets of guidance will be discussed in turn, starting with the smoking cessation guidelines.

## **2.2. The Smoking Cessation Guidelines**

The following section will highlight the key issues outlined in the smoking cessation guidelines for the UK, which underpin the national strategy. Unless otherwise stated, they refer to both *Thorax* guidelines (Raw *et al.*, 1998a), and the adapted Smoking Cessation Guidelines for Scotland (HEBS & ASH Scotland, 2000).

### **2.2.1. Recommendations for primary care**

Given that patient contact in primary care constitutes most (approximately 90%) of all patient contact with the NHS (Mant, 1997), the guidelines identified the routine and opportunistic, provision of brief advice and follow-up in primary care as underpinning the smoking cessation strategy in the UK. Importantly, decisions to

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<sup>1</sup> The Scottish Guidelines were updated in 2004 (Health Scotland & ASH Scotland, 2004).



provide smoking cessation support would not necessarily be mediated by professional *discipline*, but by the health professionals' level of access to patients, as well as their level of experience, commitment, and training. Thus, the provision of smoking cessation support would be open to a wide range of professions in primary care, including GPs, dentists, pharmacists, and nurses. In particular, the potential influence of GPs and pharmacists were particularly highlighted, because of their high level of contact with patients<sup>1</sup>. Under the recommendations, any smoker wishing to quit would be able to access these smoking cessation services effectively, which were to be tailored to the different motivational needs of smokers. The smoking cessation guidelines for Scotland (HEBS & ASH Scotland, 2000) described this as a *stepped care approach*, whereby intervention was to be determined by motivation to quit and levels of dependency.

It was recommended that brief interventions involve five key steps: *Ask*, *Assess*, *Advise*, *Assist*, and *Arrange*. In practice this would mean that on contact with patients, health professionals would *ask* about and record their patient's smoking status at every opportunity, *assess* interest in quitting, highlight the dangers of continued smoking and *advise* them on the benefits of quitting. Subsequently, if a smoker should wish to quit, the health professional would *assist* the smoker in doing so. This would involve working with the patient to set a quit date- discussing potential problems that may affect their ability to quit, and ways of dealing with such problems. Nicotine Replacement Therapy (NRT) was also considered to play a key role in the cessation process, given the evidence-base on its impact on quit rates. Health professionals would also *arrange* a follow-up visit (after 1 week) to monitor progress and further visits after this if possible. If the patient experienced difficulty in quitting, the health professional would refer them onto a *specialist smoking cessation service* for more intensive support.

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<sup>1</sup> Every year, around 80% of the population consult their GP (Fowler, 1997), with this percentage being higher for smokers (Office of population Censuses and Surveys, 1996), and approximately 68% of the population visiting their pharmacist on at least a monthly basis (McElroy *et al.*, 1993).



### **2.2.2. Role of the Specialist Smoking Cessation Service**

The main function of the specialist smoking cessation service was to support patients who were unable to quit through brief interventions. The essential ingredients of specialist cessation support was to deal with a client's motivation to quit, incorporating skills training, social support, and relapse prevention. This would be facilitated by a skilled health professional, *trained* in providing specialist support. Although it was proposed that specialist services could be located within general practice, it was recognised that this would not always be a feasible option. Therefore, specialist services could be delivered by trained professionals from a number of healthcare disciplines. This intervention would take a client-centred approach, whereby interventions would, as much as possible, be conducted in groups (although one-to-one support could also be an option for those clients who preferred this approach), amounting to approximately five/six one-hour sessions. All clients would be expected to quit smoking after their first session. An integral component of the specialist smoking cessation services would also be to offer and encourage the use of NRT, where appropriate. A further important aspect of the service would be to follow-up the progress of clients to establish smoking status at one, three, six and twelve months.

### **2.2.3. NRT (Nicotine Replacement Therapy)**

Evidence suggests that NRT can approximately double the chances of quitting smoking compared to controls (given a placebo or no NRT), and this figure stands whether there is the provision of additional support or not (Silagy et al., 1998; Fiore et al., 1996). At the time of the initial guidelines (1998/1999), most NRT products were Pharmacy products, and not available on prescription. However, the White Paper 'Smoking Kills' advocated that a one week supply of NRT should be made available to those least able to afford it, if they were undertaking specialist cessation support. Criteria for eligibility for this one-week supply of NRT was the same as that for obtaining free prescriptions. NRT however at this stage was contraindicated for pregnant smokers, and also largely for those under 18 years of age. The role of healthcare professionals was to provide accurate information and advice around the use of NRT.

#### **2.2.4. Priority Groups**

In line with the Government targets set out in *Smoking Kills*, the smoking cessation guidelines highlighted the importance of targeting young people, pregnant women, and low-income groups. The targeting of low-income groups was considered to be a particular priority. Hence, it was recommended that services consider ways of increasing the availability NRT to this group, for instance at a reduced cost. With regards to the other two priority groups, it was recommended that pregnant smokers be given clear and consistent advice around cessation throughout their pregnancy. For young people, it was proposed that the smoking cessation service should be offered to this group of smokers, “*with the content modified as necessary*” (Raw *et al.*, 1998a p.13), and that specific smoking cessation interventions for young people should developed and evaluated (HEBS & ASH Scotland, 2000). While it was recognised that the use of NRT products might be appropriate and effective, this was still under review.

#### **2.2.5. Commitment to smoking cessation (particularly at the primary care level)**

As well as outlining the role of health professionals and the specialist smoking cessation services, the guidelines also made recommendations for health commissioners. It was proposed that the guidelines for the development of smoking cessation services should be incorporated into the Health Improvement Programme of Health Authorities (England) and Health Boards (Scotland). Thus, this would maintain the status of the guidelines as important strategies for health, recognising their importance in achieving health service targets. Additionally, guidelines by the NHS Executive (Department of Health, 1999b) proposed that Health Authorities and Primary Care Groups should work together to develop local strategies and targets as part of the Health Improvement Programme. Similarly, the smoking cessation guidelines for Scotland advocated that Primary Care Trusts should incorporate smoking cessation strategies into Local Health Plans, which establish local priorities. Essentially, it was advocated that smoking cessation should become a core activity within the health care system.

### 2.2.6. Staff and Training requirements

The smoking cessation guidelines advocated that staff training was a vital component of the smoking cessation service, and that the training of healthcare staff in smoking cessation methods should be a core strategy and priority. This would not only involve the provision of training courses and materials, but also the *promotion* of training, so that it formed an integral part of the service. The requirement to allow for protected time and funding for such activity was also highlighted.

### 2.2.7. Auditing and monitoring

The guidelines recommended that systems for auditing and monitoring smoking cessation services be developed. More specific guidance however was provided outwith the guidelines, through Governmental documentation, particularly in England. This Governmental guidance will be discussed in section 2.3.

### 2.2.8. Evidence-based smoking cessation services

*Evidence-based practice* has increasingly become a central tenet of policy-making in the UK. The establishment of the Research and Development Strategy within the Department of Health in 1991 was underpinned by the notion that “*strongly held beliefs rather than sound information still exert too much influence on health care*” (Peckham, 1991). ‘Evidence-based’ approaches also incorporate the element of cost-effectiveness. When the Labour Government came to power in 1997, their central policy to tackle health inequalities in the UK was underpinned by a focus on evidence-based and cost-effective practice:

*[The Government] “wanted to obtain advice from the public health community about how to reduce inequalities, but it set clear limits about what it would find acceptable: the government wanted the advice quickly, the advice had to be backed by the evidence about **what works** and the recommendations had to fit with the government’s policy of **not increasing public expenditure**”* (Macintyre *et al.* 2001, p.224, emphasis added)

There has therefore been an increasing commitment by Government to evidence-based and cost-effective practice. The smoking cessation guidelines were developed in accordance with a strong evidence base. This evidence-base constituted an integral

part of the guidelines, with recommendations endorsed with evidence of effectiveness (Raw *et al.*, 1998b). Brief advice by a clinician to stop smoking, versus no such advice, has been shown to increase the percentage of smokers quitting for 6 months or longer by 2%, and 8% for intensive support (Fiore *et al.*, 1996). With regards to NRT, as outlined previously, this has been shown to roughly double smoking cessation rates, whether extra support is provided or not (Silagy *et al.*, 1998; Fiore *et al.*, 1996).

Smoking cessation interventions have not only been shown to be effective, but also cost-effective, “*guaranteed to bring population health gains, for relatively modest expenditure*” (Raw *et al.*, 1998b, p.S5). An informal marker for recommending the implementation of new clinical treatments is around £20,000 per quality adjusted life year gained (NICE, 2004). Smoking cessation interventions however demonstrate excellent cost-effectiveness, ranging from around £600 per life year gained for those aged 35-44 years, and £750 for those aged 45-54 years (Stapleton, 2001). The NHS smoking cessation strategy, therefore, offered a resource-intensive and effective means of tackling one of the most significant causes of morbidity and mortality in the UK, and sat comfortably within the political climate of evidence-based practice. However, the challenge lay in rolling this strategy out into practice.

### **2.3. Government Guidance (and updated Thorax guidelines)**

The smoking cessation guidelines provided a blueprint for the development of smoking cessation services. However, additional guidance around the development, and prioritisation of, the smoking cessation services was also provided by the Department of Health and The Scottish Executive (formally The Scottish Office), and set out in White Papers, NHS Circulars, and other official documentation. Undated *Thorax* guidelines also provided additional direction, particularly around the role of pharmacological support. Some of the key guidance provided is outlined below.

### **2.3.1. Auditing/Monitoring of smoking cessation services**

The smoking cessation guidelines (Raw *et al.*, 1998a, HEBS & ASH Scotland, 2000), recommended that a monitoring system be put in place for the smoking cessation services. As a new strategy, it was important to monitor the success of NHS smoking cessation interventions. The Scottish Office/The Scottish Executive, and the Department of Health in England provided direction on the monitoring of the services, although the situation differs substantially between Scotland and England. In England, the collection and monitoring of the same *minimum data set* was required by all Health Authorities (Department of Health, 1999b). Included in this data set (amongst others) was a description of elements of the service, numbers of smokers receiving treatment (demographically defined, and including how many received free NRT), and quit rates at 1 month, 3 months, and 12 months (demographically defined). The monitoring requirements were updated in 2001 (Department of Health, 2001). One of the changes was that only the four-week follow-up data was formally required (four weeks after the quit date), with 12-month follow-up data only to be collected for local, and not central, monitoring purposes.

English smoking cessation services were also set throughput targets for the smoking cessation services. These targets related to smokers who were treated by the services and had stopped smoking at the end of four weeks of treatment. Annual statistics are published on these figures. The most recent national target was set at 800,000 for the period 2003-2006 (Department of Health, 2002a). This is equivalent to at least 900 successful quitters at the end of four weeks of treatment per average Primary Care Trust<sup>1</sup> (Health Development Agency, 2003). This figure was a considerable increase on the 100,000 national target for 2002-03, which was equivalent to 333 per average Primary Care Trust (Health Development Agency, 2003). The national target for 2001-02 was 50,000, which was equivalent to 167 per average PCT.

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<sup>1</sup> PCTs became the main commissioning body for the smoking cessation services following the abolition of Health Authorities and the creation of Strategic Health Authorities.

In England, therefore, there was strong guidance around monitoring procedures, and through-put targets. However, in Scotland this was not the case. Although the smoking cessation guidelines for Scotland (HEBS & ASH Scotland, 2000), and The Scottish Office (The Scottish Office, 1999b) highlighted the importance of monitoring the services, there was no central monitoring system developed as there was in England. Scottish Health Boards were assigned responsibility to develop their own monitoring systems. Although the same basic data around the number of patients receiving smoking cessation support, intervention type (groups/one-to-one and pharmacological interventions), and demographics was being collected, it was difficult to establish a national picture of the success/impact of local services, given the variations in monitoring procedures. The Scottish Executive Health Department contacted all Health Boards in 2001 to collect information about various aspects of the services that had been set up in each Health Board (The Scottish Executive, 2001a). This revealed that Health Boards were using various definitions of a “successful quitter” (ranging from 3 months reported abstinence to 12 months), and that there was considerable variability in the monitoring data available from each Health Board<sup>1</sup>. The monitoring system in Scotland has, however, been under review, and a Scottish Executive funded initiative, Partnership Action on Tobacco and Health (PATH) was set-up in June 2002. This focussed efforts on the development of a central Scottish monitoring system, which is currently in the process of being implemented. This issue will, however, be discussed in more detail in chapter nine (Discussion), within the context of my research findings.

### **2.3.2. Dedicated staff / smoking cessation co-ordinator**

It was recommended that staff should be recruited to manage/co-ordinate the smoking cessation services (The Scottish Executive, 2001a; The Scottish Office, 1999b; Department of Health, 1999b). Specifically, it was proposed that a service co-ordinator should be appointed for each locality, who would primarily have responsibility for ensuring the structures of the service were in place. This would include co-ordinating the training procedures, the monitoring process, and being the

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<sup>1</sup> Written feedback (“Smoking Cessation Returns”) from this exercise was provided by The Scottish Executive to relevant Health Board staff. This feedback was provided to me by the Smoking Cessation Co-ordinator of the Health Board under study.



point of contact for the agencies involved in the service delivery (GP Practices; Primary Care Groups/Trusts; Pharmacists; Dentists; Community Nurses etc).

### **2.3.3. Pharmacological interventions: NRT and Zyban (Bupropion)**

At the time of publication of the initial *Thorax* guidelines (Raw *et al.*, 1998a) NRT was not available on prescription. The introduction of a Voucher Scheme system to provide a free supply of NRT was strongly recommended (Department of Health, 1999b). Under this scheme, a client eligible for free prescriptions would be provided with an NRT voucher from their smoking cessation support provider. This voucher could be exchanged for NRT from local pharmacies (upon assessment by the pharmacist and evidence of eligibility), and the pharmacists would then be reimbursed for the cost of the NRT (from the allocated NRT budget).

The updated *Thorax* guidelines (West *et al.*, 2000) however, recommended that NRT should be made available on reimbursable prescription. Indeed, on 17<sup>th</sup> April 2001, NRT was made available on prescription, and the voucher scheme was no longer operational. With regard to the issue of tackling health inequalities, this had major implications for those in low-income groups, who could subsequently receive NRT free on prescription for as long as was required. The updated *Thorax* guidelines (West *et al.*, 2000) proposed that the use of NRT by pregnant smokers may have some benefit for both the mother and the foetus, if the quit attempt was successful. In addition to this, a review critiquing the regulation of NRT advocated that there would be some benefit in prescribing NRT to pregnant smokers, minors, and those with cardiovascular disease (McNeill *et al.*, 2001). In this review, it was argued that this would be less harmful than the continued use of tobacco. In part recognition of this, the Committee of the Safety of Medicines recommended that certain NRT products be made available on general sale from the 31<sup>st</sup> May 2001.

Another pharmacological intervention was, however, identified as an important smoking cessation aid after the initial *Thorax* guidelines were published in 1998. This was Zyban (Bupropion), which was first developed and used as an anti-depressant in the USA. Although the mechanisms by which Zyban aids smoking

cessation are still unclear, they are thought to be linked to the inhibition of reductions in levels of dopamine and noradrenaline, which takes place during nicotine withdrawal (Roddy, 2004). When it was first released as a potential smoking cessation aid, Zyban attracted a large amount of media attention in the UK. This centred around its potential serious side effects, the most serious of which are seizures (Roddy, 2004).

The Department of Health's statement on Zyban in July 2000 (Department Health, 2000a) supported the use of Zyban in helping smokers who were motivated to quit, in conjunction with motivational support. It stated that Zyban would be available from the 26<sup>th</sup> June 2000. However, it would be at the discretion of the GP to prescribe the drug within the context of the clinical consultation. The updated *Thorax* guidelines (West *et al.*, 2000) reviewed the evidence on Zyban as a smoking cessation aid. While the outcome of this review recognised Zyban as an effective aid to smoking cessation, it noted that evidence of its effectiveness was limited to medium to heavy smokers. In conjunction with *intensive support*, Zyban is reported to double the chances of long-term cessation (Fiore *et al.*, 2000). The role of the smoking cessation services was to provide information and advice about Zyban. The National Institute of Clinical Excellence appraisal of NRT and Zyban, published in 2002 (NICE, 2002), highlighted the cost-effectiveness of both Zyban and NRT, and recommended their use for smokers motivated to quit. Given that the Smoking Cessation Guidelines for Scotland were published in 2000, they included guidance around the use of Zyban. The guidelines recommended its use (where appropriate) as a smoking cessation aid, again, in conjunction with intensive smoking cessation support.

#### **2.3.4. UK health policy beyond *Smoking Kills***

In Scotland, and the rest of the UK, the continued priority assigned to smoking cessation was highlighted in various publications. The need to tackle smoking was outlined in national strategies for cancer (The Scottish Executive, 2001b; Department of Health, 2000b), and coronary heart disease (The Scottish Executive, 2002b), with the latter reiterating the need to address smoking in low-income groups in particular.



A public health paper specifically on smoking was published in 2003 (NHS Health Scotland & ASH Scotland, 2003). This pinpointed strategies to reduce smoking as key to changing the health of Scottish people, and recommended a comprehensive national tobacco control strategy. The long term funding of the smoking cessation services was implicated in constituting a key part of this strategy. The subsequent White Paper, *Improving Health In Scotland: the Challenge* (The Scottish Executive, 2003a) again placed importance on the need to tackle smoking, and put political will behind plans to review Scotland's tobacco control policy. Subsequently, in 2004, a tobacco control action plan was published- *A Breath of Fresh Air for Scotland* (The Scottish Executive, 2004b). The precise details and implications of this document, and other public health documents for Scotland, will be discussed in the final chapter of the thesis, where they will be linked to the findings and implications of this research.

### **2.3.5. Summary**

*Smoking Kills* outlined plans to implement the first national smoking cessation strategy in the UK. The smoking cessation guidelines provided the blueprint for these new services, and amongst other recommendations, advocated the provision of brief advice and follow-up in primary care as integral to their structure. Smoking cessation support would be tailored to the different motivational needs of smokers, from brief interventions to intensive smoking cessation support, in addition to the provision of pharmacological support. These new NHS smoking cessation services represented a shift from a primarily 'opportunistic' health promotion model, consisting of opportunistic smoking cessation advice within the GP consultation, to a significantly more comprehensive and structured means of reducing smoking prevalence in the UK.

## **2.4. Evaluation of English Smoking Cessation Services**

Since 1999 there has been an ongoing and comprehensive evaluation of the smoking cessation services in England, funded by the Department of Health's Policy Research Programme. There has not been a similar evaluation, or systematic investigation, of service development and implementation in Scotland. While this PhD research is not

an *evaluation* of Scottish services, the English evaluation research provides important insights into the key issues around smoking cessation service development, which are of relevance to this thesis.

The English evaluation of smoking cessation services has incorporated a range of research projects, focussing on several aspects of service development, implementation, and impact. The first piece of research related to the development of services within Health Action Zones (Adams *et al.*, 2000). Health Action Zones (HAZs) relate to specific geographical areas in England, and were developed to tackle the issue of health inequalities. It was in these areas that the Government targeted the first year of smoking cessation service development in England, and a total of £10 million was allocated to the HAZs for twelve months, from April 1999. Evaluation research around the development of services within the HAZs, as outlined in Adams *et al.* (2000), consisted of semi-structured interviews with HAZ smoking cessation co-ordinators, additional semi-structured interviews with key smoking cessation staff in seven of the HAZs (which were viewed as in-depth case studies), and the analysis of monitoring returns and additional data supplied by the HAZs. This one-year study of the development of services within the HAZs was followed by research into the development of services throughout the rest of England.

The subsequent key stages of the national evaluation included the following: postal surveys of smoking cessation co-ordinators in April 2001 and April 2002 (details in Pound *et al.*, 2005); semi-structured interviews with 50 smoking cessation staff in two English Health regions in Autumn 2001 (details in Coleman *et al.*, 2005); and 28 semi-structured interviews in the Autumn of 2002 with staff interviewed in the previous round (details in Coleman *et al.*, 2005; Bauld *et al.*, 2005). Quantitative data pertaining to, for instance, demographics, the setting of quit dates, and 52-week quit rates was also analysed to provide information on service reach and smoking cessation outcomes (details in Chesterman *et al.* 2005; Ferguson *et al.* 2005). Together, these research projects highlighted various key issues around smoking cessation service development and implementation. The main research findings that

are relevant to this thesis can be divided into five areas: staffing; interventions; primary care and the smoking cessation services; monitoring; and targeting.

#### **2.4.1. Staffing**

Key issues regarding staffing of the smoking cessation services centred around recruitment and retention. In the development of services within the Health Action Zones (HAZs), it was found that the recruitment of smoking cessation co-ordinators occurred over a nine/ten month period (Adams *et al.*, 2000). This consequently incurred delays on service development, particularly as the recruitment of additional staff (e.g. administrative staff and specialist support providers) tended to follow the appointment of a co-ordinator (Adams *et al.*, 2000). The recruitment of suitably *qualified* staff to fill specialist smoking cessation roles also proved to be a stumbling block in the early stages of service development in England. In the Health Action Zones, for example, there was a problem with Health Authorities attempting to recruit from the same pool of staff (Adams *et al.*, 2000). The necessity to train-up smoking cessation advisors, also detracted co-ordinators from attending to other areas of service development (Coleman *et al.*, 2005).

The key issue, however, around the recruitment and retention of staff appeared to be the nature of the contracts on offer, which was underpinned by the funding structure for the smoking cessation services. As outlined by Bauld *et al.* (2005), the central White Paper funding ended in March 2002, with an extra year's funding announced in December 2001 (commencing in April 2002), and indications of an additional three years' funding (April 2003- April 2006) being announced in December 2002. Due to the uncertainties around recurring funding (particularly as additional funding was announced very close to the end of existing contracts), it was difficult to plan the longer-term strategic development of smoking cessation services (Bauld *et al.*, 2005). Consequently, short-term contracts, and the lack of proper career structure, had the impact of deterring staff from taking up posts, and in staff leaving to other more secure posts (Bauld *et al.*, 2005; Coleman *et al.*, 2005). Bauld *et al.* (2005) recommended a clear commitment to the long-term recurrent funding of services to counteract this problem.

## **2.4.2. Interventions**

### ***2.4.2.1. Impact of NRT & Zyban on prescription***

The availability of NRT and Zyban on prescription had a considerable impact on demand for smoking cessation services in England (Bauld *et al.*, 2005). Underpinning this impact on demand was (a) the increased publicity for pharmacological therapies (particularly regarding Zyban), and (b) the requirement for Zyban to be prescribed alongside intensive smoking cessation support, which placed additional demands on specialist services (Bauld *et al.*, 2005). Both of these factors were implicated in causing “*rapid and unpredictable fluctuations in demand for smoking cessation services [...] at a relatively early stage in their development*” (Bauld *et al.*, 2005, p.24).

### ***2.4.2.2. One-to-one/Group support***

The English Evaluation of Smoking Cessation Services reported that in the early stages of service development, group support was the most common method of service delivery (Bauld *et al.*, 2005). Given that there was a high demand for services in the early stages of service development, group support emerged as the preferred method of service delivery. Less staff were required for conducting group support (compared to one-to-one support), and it was perceived to be more cost-effective (Bauld *et al.*, 2005). However, as the services developed beyond their initial set-up stage, it was noted that the provision of one-to-one support increased (Bauld *et al.*, 2005). This increase in one-to-one support was largely attributed to (a) patient preference for one-to-one support due to the greater privacy and flexibility offered by this method, and (b) increasing numbers of smoking cessation support providers being trained (Bauld *et al.*, 2005). In delivering smoking cessation support, Bauld *et al.* (2005) also reported that service development was informed by the specific geographic/structural make-up of local areas. For instance, in rural areas in particular, one-to-one support was reported as being more prevalent, due to the difficulties in co-ordinating groups (Bauld *et al.*, 2005).

### **2.4.3. Primary care and the smoking cessation services**

The smoking cessation guidelines (Raw *et al.*, 1998a) clearly highlighted the central role of primary care as underpinning the smoking cessation strategy in the UK. However, the Evaluation of the English Smoking Cessation Services has highlighted difficulties around the development of smoking cessation services within primary care. Smoking cessation co-ordinators within English Health Authorities were keen to develop services in close contact with primary care, in order that primary health care professionals could deliver smoking cessation interventions, and/or refer patients for support (Coleman *et al.*, 2005).

However, the English Evaluation research indicated that in the early stages of service development, there was opposition from primary care to the smoking cessation strategy (Coleman *et al.*, 2005; Adams *et al.*, 2000). Much of this opposition appeared to be centred around General Practice (Coleman *et al.*, 2005; Adams *et al.*, 2000). There was a reported reluctance from GPs to allow practice nurses to receive training for providing smoking cessation support (Adams *et al.*, 2000), and there were issues around funding and 'core' work (Coleman *et al.*, 2005). Whereas some smoking cessation co-ordinators felt that smoking cessation support should be delivered as part of the clinical workload, GPs tended towards the view that this element of practice staffs' work required additional funding (Coleman *et al.*, 2005).

It was also reported that some GPs expected smoking cessation service providers to pay for using primary care premises to deliver their services, although in such cases other locations were commonly found (Coleman *et al.*, 2005). Additionally, Coleman *et al.* (2005) reported that smoking cessation co-ordinators perceived there to be a need to persuade GPs, and other health professionals, of the importance of smoking cessation interventions in primary care. Despite these difficult early interactions however, services proceeded to develop within primary care, with General Practice and other primary care settings (in addition to non-primary care venues) playing a prominent role in service delivery by 2002 (Bauld *et al.*, 2005). Raw *et al.* (2005) reported that by 2002, over 90% of smoking cessation services were using the General Practice setting for support provision.

#### **2.4.4. Monitoring**

Research carried out on smoking cessation service development in Health Action Zones, and English Health Authorities more generally, has highlighted some key issues regarding the monitoring process. Firstly, the monitoring process was perceived by smoking cessation co-ordinators as being particularly time consuming, given the effort required in setting-up databases and collating data (Adams *et al.*, 2000). The time required to fulfil these requirements was viewed by smoking cessation co-ordinators in the context of other service development requirements, such as training staff and delivering support (Adams *et al.*, 2000). Adams *et al.* (2000) also reported difficulties in obtaining monitoring forms from those professionals providing smoking cessation support. Key difficulties associated with collecting monitoring data included (a) reluctance of health care professionals to use or return monitoring forms (given that the monitoring procedure was different from existing methods of monitoring in primary care), (b) monitoring forms not being used or returned due to time constraints, and (c) only monitoring forms for 'successful' quitters being returned. There were also different perceptions around how the concept of 'success'. Specifically, some professionals involved in the smoking cessation service argued that the monitoring forms did not allow for the collection of data on those clients who had reduced the number of cigarettes they smoked daily, but not quit (Adams *et al.*, 2000).

#### **2.4.5. Targeting**

*Smoking Kills* (Department of Health, 1998a) and the subsequent smoking cessation guidelines (Raw *et al.*, 1998a) highlighted the importance of tackling three particular groups of smokers: young people; pregnant smokers; and low-income groups. The evaluation of the English smoking cessation services offers an insight into the services in reaching these three groups of smokers.

The postal surveys of smoking cessation co-ordinators indicated that in 2001, 91% of co-ordinators reported that their services were trying to attract priority groups, and in 2002 this had increased to 100% of co-ordinators (Pound *et al.*, 2005). However, despite the high percentage of co-ordinators reporting that services were trying to



attract priority groups, the qualitative data highlighted that limited strategies had been developed for reaching these particular groups.

Out of the three target groups, smoking cessation service staff have reported being most able to reach low-income groups (Pound *et al.*, 2005; Adams *et al.*, 2000). As outlined by Chesterman *et al.* (2005), a sample of 19 English health regions indicated that smoking cessation services were successful in attracting smokers from the most disadvantaged areas (32.3% of smokers who received smoking cessation support, compared with 9.6% in the most advantaged areas). Locating smoking cessation services in accessible venues within economically deprived areas was reported as being the main approach adopted by smoking cessation staff for increasing accessibility of smoking cessation services for low-income smokers (Pound *et al.*, 2005). This method of attracting low-income smokers, in addition to the priority assigned by the Department of Health to reaching low-income groups, are two factors that have been implicated in the success of English smoking cessation services in reaching this group (Chesterman *et al.*, 2005). However, it has been highlighted that in order for the services to effectively contribute to reducing inequalities in health, then *reach* must also be accompanied by *successful quitting* in the long term (Chesterman *et al.*, 2003). Research is currently underway to establish the long-term effectiveness of smoking cessation interventions (Ferguson *et al.*, 2005)

There has, however, been less reported success in reaching pregnant women and young people. Of the three target groups, young people were perceived to be the lowest priority. As outlined in Pound *et al.* (2005), in 2001, people with smoking-related illnesses were prioritised over young people by smoking cessation co-ordinators (Pound *et al.*, 2005). There was a perception amongst service staff that in order to reach young people, a different strategy to that which targeted adult smokers was required, and few developments were made by services to attract this group of smokers by 2002 (Pound *et al.*, 2005). More evidence and guidance was perceived to be required for the development of effective treatment interventions for young people (Raw *et al.*, 2005).

Regarding pregnant women, evaluation of the smoking cessation services in Health Action Zones highlighted two key barriers to the development of services to reach pregnant women (Adams *et al.*, 2000). These barriers were (a) inadequate links between the smoking cessation services and the midwifery profession, and (b) the inability of service providers to offer NRT (it was contraindicated for pregnant women at this stage). In 2001, strategies for reaching this group of smokers in English Health Authorities were still largely under-developed (Pound *et al.*, 2005). However, following the allocation of dedicated funding for the development of services for pregnant women (Department of Health, 2002), many smoking cessation services employed a key staff member to lead the development of strategies aimed at this group (Pound *et al.*, 2005). However, although the types of services offered to pregnant women once they were actually *using* the services were tailored to meet the needs of this group more effectively (e.g. providing smoking cessation support at home), strategies for *attracting* pregnant women to services remained under-developed (Pound *et al.*, 2005).

The Evaluation of English Smoking Cessation Services, therefore, suggests that services has been successful in reaching low-income groups, but have had limited success in reaching young people and pregnant smokers. One key factor implicated in the limited success of smoking cessation services in reaching the three target groups, is the impact of the formal throughput targets set by the Department of Health (Pound *et al.*, 2005). To re-iterate, these throughput targets monitored the number of smokers attending services, setting quit dates, and quitting at 4 weeks. Research with smoking cessation co-ordinator and service staff indicated that the perceived importance of reaching the throughput targets surpassed the need to develop services to reach the three priority groups, for which no formal targets had been set (Pound *et al.*, 2005). Consequently, this delayed the development of services to reach young people, pregnant women and low-income groups (Pound *et al.*, 2005).

#### **2.4.6. Summary**

This section has highlighted some of the key findings from the evaluation of smoking cessation services in England. The final chapter of this thesis will discuss the



English evaluation research further within the context of the literature and my PhD research findings. However, it is clear that there were difficulties and/or tensions around targeting, funding and staffing. Additionally, the introduction of NRT and Zyban on prescription was reported to have a significant impact on service demand, and consequently on service development. Also highlighted were barriers to strategy implementation at the primary care level, particularly regarding GPs. The focus on throughput targets demonstrated the potential impact of target-setting on service development, particularly with regards to reaching the three target groups.

## **2.5. Health Promotion and Primary Care**

### **2.5.1. Health promotion and the primary care team**

#### ***2.5.1.1. GP contracts and the practice nurse***

The GP contracts of the 1990s were designed to encourage the development of health promotion activities within primary care, and specifically within general practice. These contracts put General Practice at the forefront of health promotion development in primary care. The principal outcome of this was the increasing emergence of the practice nurse, who was employed to ‘absorb’ this additional component of the general practice workload through a delegation process (Hopton, 1996; Broadbent, 1998; Naidoo & Wills, 1998). The number of practice nurses increased significantly, with an estimated trebling of numbers between 1988 and 1998 (Department of Health, 1999c).

A review paper exploring the impact of the 1990 GP contract on the working practices of practice nurses and GPs (Broadbent, 1998), presents a good example of the delegation process. Broadbent discussed how the introduction of the GP contract saw the development of a health promotion role evolving for practice nurses, rather than GPs. General Practitioners reported that health promotion was not within their remit, and practice nurses became part of what has been termed an “absorbing mechanism” (Laughlin *et al.*, 1994a,b; Laughlin & Broadbent, 1995; Broadbent & Laughlin, 1997). This process represents the ‘absorption’ of work meant for GPs by

practice nurses, to allow for GPs to continue with the work that falls within their 'traditional' remit. Whereas GPs were ambivalent about incorporating health promotion into their daily practice (the reasons for which will be discussed shortly), Broadbent (1998) found that practice nurses welcomed the licence to do so. Practice nurses perceived health promotion activity as conducive to their own professional work remit, felt they had more time to carry out health promotion activities, and were keen to develop professional autonomy in this area of work (Broadbent, 1998). This 'specialist' role emerging for practice nurses in the delivery of health promotion activities has been outlined elsewhere (Hopton, 1996), and health promotion activity has been reported to be a low priority amongst GPs despite the financial incentives offered by the contracts (Shiroyama *et al.*, 1995). This leads onto the consideration of an important issue around the delivery of health promotion in primary care. This issue relates to where health promotion is perceived to fit within traditional roles and working practices, and/or models of healthcare provision.

#### ***2.5.1.2. Health promotion, orientations, and working practices***

Hopton's (1996) study, referenced above, is particularly relevant here, because it involved a substantive qualitative study of health promotion practice in primary care in Scotland. Hopton's study involved three projects, which combined looked at the role of health promotion within the working practices of health professionals in primary care. The first project (January 1994) involved interviews with 26 GPs around the issue of a specific health promotion training initiative. The second project (April 1994) explored background issues around health promotion in primary care, involving interviews with 38 members of the primary health care team from three demographically varied practices. The third project (October 1995) involved interviews with members of the primary health care team beyond those linked to general practice (e.g. community pharmacists and psychiatric nurses), and investigated the perceptions of their health promotion role. The findings from the three projects were collated and presented in a research report (Hopton, 1996). Although it is not possible to outline all the findings from this research, some of the key findings that are particularly relevant for this thesis are outlined throughout this section of the literature review.

One important finding from Hopton's research was that health promotion was incorporated into a health professional's work in three different ways. First of all, health promotion could be perceived by health professionals as a personal commitment, where there appeared to be a 'moral obligation' to promote health. Second, it could be viewed as 'integral part' of a health professional's work, whereby it was perceived to be something that was done in day-to-day practice anyway, and was therefore encompassed fundamentally within work practices. Finally, health promotion could be regarded as a 'specialism' whereby some health professionals had a formal remit for carrying out health promotion activities, for instance through ring-fenced time or delegated tasks.

Most health professionals in Hopton's (1996) study appeared to perceive health promotion as integral to their day-to-day work. However, Hopton discussed that when health promotion was defined as a 'specialism', health professionals were then able to identify barriers to carrying out this aspect of their work, and to perceive it as an activity that had to be prioritised. When balancing priorities however, and taking into account limited resources and other demands on health professionals' time, health promotion could be surpassed by other priorities. Hopton (1996) commented upon this 'paradox' between health professionals' reflections on health promotion as being integral to their work, but also as something that could be prioritised- and therefore *not* integral.

Hopton (1996) distinguished between *psychosocial* and *disease-orientated* approaches, and *patient* versus *professional-centred* approaches, and their implications for health promotion practice within General Practice. Specifically, it was found that GPs could approach their work in quite different ways. Whereas some GPs adopted a client-centred approach (where the consultation was more psychosocial and focused on more than just the 'illness'), other GPs adopted a very disease-orientated approach to their work. With regards to the latter approach, GPs felt their primary role was in the *treatment* of illness rather than in *preventing* illness in the wider population through the provision of lifestyle advice. This reflects wider debate around the role of GPs in *primary* and *secondary prevention* efforts. Primary

prevention aims to prevent the onset of disease/illness through preventive interventions (e.g. immunisation; screening for risk factors; lifestyle advice), whereas *secondary prevention* aims to prevent the progression of ill-health (e.g. statin therapy for hypertension) once it is detected (Naidoo & Wills, 2000). There is an inherent tension in the General Practitioner's role, between traditional orientations towards treating illness, and in seeking opportunities to prevent ill health (Naidoo & Wills, 1998). However, research indicates that GPs consider the former to be more appropriate and relevant in terms of professional practice (William & Calnan, 1994; Williams & Boulton, 1998), and that this profession places greatest importance on their 'curative care' role (Bradley & McKnight, 1997). This suggests that GPs may operate within a disease-orientated and secondary prevention framework.

Research has indicated that, more so than GPs, the nursing profession perceive health promotion to fall within their working remit (Steptoe *et al.*, 1999; Broadbent, 1998). In a qualitative study looking at attitudes towards cardiovascular health promotion amongst GPs and practice nurses in the UK, Steptoe *et al.* (1999) found that GPs were more likely to agree that their job was to 'treat disease' and that health promotion should be 'left to others'. In terms of risk factor identification, both GPs and practice nurses in the study agreed that the identification of smoking and hypertension were important in their work. Although, significantly more practice nurses felt that the detection of other risk factors (i.e. high cholesterol; obesity; physical inactivity) was a part of their role. A further interesting finding from Steptoe *et al.*'s (1999) study was that practice nurses were more likely to consider that health promotion, in the form of lifestyle counselling, would be *effective* in reducing cardiovascular risk factors amongst patients. Perception of effectiveness is a key issue in the implementation of health promotion practice in primary care. It has been suggested that one barrier to smoking cessation interventions by GPs is a perception of limited impact (Fiore *et al.*, 1996; Owen & Scott, 1995).

A qualitative study by Lawlor *et al.* (2000), which investigated GPs' attitudes towards providing lifestyle advice in consultations, found that GPs were most comfortable with adopting a *secondary prevention* role, through managing medical

problems, as opposed to preventing illness. GPs in this study (Lawlor *et al.*, 2000) proposed that other members of the primary care team were more suited to undertaking the primary prevention role. GPs reported that a focus on providing lifestyle advice- particularly when out of context of a patient's medical problem- could perpetuate victim-blaming.

Victim-blaming has been associated with the medical and behaviour change approaches to health promotion that place the onus largely on the individual to take responsibility for their own health, whilst ignoring the wider socio-economic influences of health (Naidoo & Wills, 2000). Indeed, in addition to having a perceived negative impact on the doctor-patient relationship, GPs in Lawlor *et al.*'s (2000) research were reported to have doubts about the effectiveness of such an approach, arguing that wider social and environmental factors were more important determinants of population health. As opposed to the 'expert-led' medical/preventive model of health promotion, whereby authority tends to lie with the medical profession (Naidoo & Wills, 2000), the *social change* model of health promotion focuses on changes at the structural social/political/environmental level that may impact upon health (Naidoo & Wills, 2000).

With regards to the wider determinants of health, it is unclear whether the GPs in Lawler *et al.*'s study (2000) considered this issue within a broader health promotion framework (i.e. the different models and approaches to health promotion), or viewed 'health promotion' in quite simple terms, as simply lifestyle advice/ primary prevention. Hopton (1996) found that health professionals in her study of primary care tended to have quite narrowly defined views of health promotion, with 'prevention' being the most common model adopted- particularly in terms of screening and giving lifestyle advice. Some health professionals in Hopton's (1996) were reported as criticising health promotion for neglecting the wider social, political, and economic factors that could influence health, and the potential for 'victim-blaming'.

Incorporation of health promotion activity within working practice in primary care, can, therefore, be mediated by a range of factors. One key factor is the ‘orientation’ of the health professional, and their views about how health promotion fits within existing roles, and/or can be accommodated within working practice. The literature on health promotion in primary care strongly indicates that GPs are more likely to perceive their role in secondary prevention (treatment of illness), with other practice staff tending to take on the ‘health promotion’ tasks.

#### **2.5.1.3. Delegation or Allocation?**

In recent years the ‘delegation process’ has gained increasing attention in the health policy literature, which appears to suggest that delegation may be a necessary feature of primary care practice, given the changing face of the health service. Recent research has discussed the increasing pressures that are facing primary care as a result of the shift towards a primary care-led NHS (notably increasing workload), and discusses the move towards different methods of work and team management to accommodate this (Richards *et al.* 2000; Jenkins-Clarke & Carr-Hill, 2001). The term ‘skill mix’ has been described as: “*The balance between trained and untrained, qualified and unqualified and supervisory and operative staff within a service area as well as between staff groups*” (BMA, 1995).

The process of work re-distribution within primary care has been discussed within the context of these concepts of skill-mix and delegation (Jenkins-Clarke & Carr-Hill, 2001; Richards *et al.* 2000). Specifically, with clinical work and responsibility being increasingly placed upon the whole primary health care team, Richards *et al.* (2000) suggest that traditional hierarchical models of working have less weight in the primary care setting that is increasingly being required to adopt a teamwork approach. Within this context, it is suggested by Richards *et al.* (2000) that the delegation of clinical work according to levels of skill and experience would be appropriate, in order to alleviate the burden on General Practitioners. However, it is proposed that the term *allocation* as opposed to *delegation* may be more appropriate (Richards *et al.*, 2000), whereby the latter would assume a hierarchical relationship within the primary healthcare team. Therefore, the allocation of health promotion



activities to practice nurses, or other health professionals within the primary care team, may be an effective means for GPs to manage their clinical caseload appropriate (Richards *et al.*, 2000). However, it has been suggested that by allocating this kind of work to others in the healthcare team, this may heightens the possibility that the work of GPs will be reduced simply to illness management (Charles-Jones *et al.*, 2003).

The smoking cessation guidelines outlined that the smoking cessation strategy in the UK is underpinned by the routine provision of brief advice and follow-up in primary care. GPs are one group of health professionals on the frontline of this strategy, given their access to patients, and their potential to provide brief interventions during consultations. It is crucial therefore that this particular aspect of the GPs role is not *allocated* to other members of the Practice team.

#### ***2.5.1.4. Pharmacy and health promotion***

The role of pharmacy in health promotion has been gaining increasing prominence. The image of pharmacists as simply ‘dispensers of medicine’ has been replaced by one that places the pharmacist’s role within the broader realms of promoting population health through lifestyle interventions. The smoking cessation guidelines identified pharmacists as being key to the smoking cessation strategy in the UK, based on evidence that 68% of the population visit their pharmacist on at least a monthly basis (McElnay *et al.*, 1993). Around 600,000 people visit their local community pharmacy daily in Scotland (Scottish Executive, 2002c). The potential for pharmacists to be involved in health promotion initiatives and improve population health is therefore enormous. Anderson (2000) describes pharmacists as “*knowledgeable specialists who are currently under utilised in the primary health care team*” (p.289), and highlights some of the key reasons as to why pharmacists occupy such an important position in this regard:

- The opportunities they possess to offer health advice in the context of providing prescription and over-the counter medication.
- The regular custom and ‘passing trade’ they acquire.
- Their ready availability for at least 8 hours a day without appointment.

- The fact that they consult with all members of society (ill/healthy/pregnant/different social classes).
- The opportunity they have to use window displays as a 'population strategy' for promoting health.

The expanding role of pharmacy, and its potential in improving population health, has been increasingly highlighted in government strategy publications. In 1992, a joint working party report between the Department of Health and the pharmaceutical profession (Joint Working Party, 1992), advocated the involvement of community pharmacists in wide health promotion activity. This has been reiterated in more recent policy documents. In Scotland, a recent strategy document for pharmaceutical care (The Scottish Executive, 2002c), identified pharmacists as key players in promoting healthy lifestyles, and as central to health promotion initiatives in Scotland:

*"The Health Education Board for Scotland (HEBS) and local Health Promotion Units will be asked to include pharmacies in campaigns, activities and initiatives as part of a multi-disciplinary approach to health promotion"*

(The Scottish Executive, 2002, p.7).

This leads onto a discussion of the key issues around the implementation of health promotion initiatives within this setting. Perhaps one of the earliest examples of a comprehensive, and evaluated, health promotion initiative in pharmacy was the Barnet High Street Health Scheme, launched in 1991, which influenced the widespread initiation of health promotion activities within pharmacy in the UK (Anderson, 2000). This Scheme involved training pharmacists in health promotion issues, and skills. The greatest barrier, perceived by pharmacists in the scheme, to involvement in health promotion activity, was the lack of financial remuneration (Anderson, 2000).

The importance attached to financial considerations is perhaps unsurprising, given the status of pharmacies as independent 'businesses'. In a qualitative study of health promotion in community pharmacy, it was found that over 90% of respondents stated that they would get involved in health promotion initiatives if the FHSA (Family



Health Service Authority) paid for their services (Keene & Cervetto, 1995). This was in part linked to the time involved in providing services, and the necessity of paying for locum pharmacists. In a survey of health promotion activity within community pharmacy across England (Anderson, 1996), financial consideration was again reported to be the highest reported barrier. Accounting for locum pharmacist fees (to cover the pharmacists involved in health promotion activity) was similarly found to be one prominent issue.

One issue highlighted in the literature around health promotion in pharmacy, is whether 'health promotion' activity is something that has always been part of a pharmacist's core remit, but is now just being defined in a different way (Blenkinsopp *et al.*, 2002; Keene & Cervetto, 1995). An evaluation of a community pharmacy health promotion scheme by Blenkinsopp *et al.* (2002), offers a useful insight into views around health promotion activity amongst pharmacists. The community health promotion scheme evaluated in this study was launched in 1998, and trained pharmacists in brief and extended health promotion interventions, based on the principles of the transtheoretical model/stages of change (Prochaska & DiClemente, 1984). Pharmacists were paid accordingly for each level of intervention, and the campaign centred around four areas- dental health; heart (exercise); heart (diet); and smoking cessation.

The evaluation suggested that there were various motivations for pharmacists' involvement in the scheme. These included beliefs around the importance of advancing the role of pharmacy in health promotion and the potential 'business opportunity' and financial remuneration on offer. However, with regard to one intervention in particular, smoking cessation, this was perceived by pharmacists as part of their "*existing role and expertise*" (Blenkinsopp *et al.*, 2002, p.62). Measures of client uptake and response to the scheme indicated that smoking cessation was the most successful intervention, accounting for nearly half of all brief interventions (10 minutes), and nearly 100% of the total extended interventions (20-30 minutes). In addition to the perception amongst pharmacists that smoking cessation was already part of existing roles, there was the perception that it was easier to make links with

people around the issue of smoking. Pharmacists in this evaluation noted that clients who approached them had already made the decision to quit. There was also the perceived additional benefit of being able to offer NRT to clients, which was essentially viewed by pharmacists as an effective ‘treatment’ that they could offer.

Pharmacists clearly have an important role to play in health promotion interventions, given their accessibility to the public, and their potential to offer a range of interventions, both within their existing remit and in their developing health promotion role. However, as outlined above, there are a number of issues around the involvement of pharmacists in health promotion initiatives, with financial remuneration being one prominent barrier/facilitator.

### **2.5.2. Co-ordinated health promotion activity**

The literature on health promotion practice in primary care, indicates that one factor mediating the success of health promotion interventions within the General Practice setting, is a co-ordinated approach (or lack of). An in-depth study of health promotion activity across nineteen General Practices following the 1996 GP contract, found that in several Practices, one or more of the healthcare professionals were not aware of the health promotion proposals that had been forwarded by their practice to the local health promotion committee (Coppel & Davis, 1998). This research suggested that health promotion issues were not effectively communicated or co-ordinated within the primary care team. Coppel & Davis’s research also suggested that GPs played a key role in facilitating the implementation of health promotion activities within the General Practice setting. That is, a lack of support for health promotion interventions from GPs was reported to have acted as a barrier to the provision of health promotion activity by practice nurses. Similarly, Hopton’s (1996) research indicated that Practices can have different ‘cultures’ of health promotion, with GPs acting as a significant influence on determining this ‘practice culture’.

The above highlights the importance of health professionals in one health care setting working together with a common vision for health promotion. The importance of

such a collective/co-ordinated approach to health promotion is captured in the following quotation:

*“a strategy for health promotion in primary care, for example in the general practice setting, is more than the aggregate of individual activities within the practice. It implies a targeted, multifaceted approach to the practice population based on a shared practice view of priorities for improving the health of the population”* (Doyle & Thomas, 1996, p.6).

### **2.5.3. Time and resources**

Two additional barriers to the implementation of health promotion practice in primary care, prominent in the literature, are a lack of time and resources. With regard to the former, health promotion has been described as a “luxury extra” (Naidoo & Wills, 1998, p.144). That is, health promotion may be viewed as an extra activity to be done when time allows. A lack of time for carrying out health promotion work has been cited frequently in the literature (Lawlor *et al.*, 1999; Coppel & Davis, 1998). GPs’ lack of time has been cited in several studies as a reason for their reticence towards undertaking health promotion activities (Swinburn *et al.*, 1997; Bull *et al.*, 1995; Coulter & Scholfield, 1991). Research indicates that practice nurses may consider themselves as being more suited to carrying out health promotion activities than GPs, given that they perceive themselves as having more time to do so (Steptoe *et al.*, 1999; Broadbent, 1998). A ‘lack of time’ for health promotion activities, however, has been described as indicating their low priority (Raw *et al.*, 1998a), thus suggesting that GPs may perceive health promotion as less of a clinical priority.

Linked to whether health promotion is considered an integral and important part of the primary care remit, is the issue of resources. Coppel & Davis (1998) identified a lack of resources (defined as computers, staff, and money for audit) as one of the most significant barriers to carrying out health promotion activities. Insufficient resources was also identified by Hopton (1996), who found that while health promotion activity was often facilitated in terms of staff time, the required resources were not always available to ensure efficient implementation. In essence, a lack of

both time and resource issues can act as significant barriers in the implementation of health promotion activity. Certainly these issues reflect the problem of ‘core’ versus ‘additional’ work, and raise the question as to where health promotion sits as a priority within health professionals’ remit.

#### **2.5.4. Summary**

This section has provided a background to some of the key issues around health promotion in the primary care setting that are pertinent to this thesis. In particular, it considered the role of health promotion within the wider primary care team, with reference to professional ‘orientations’/roles, and key barriers/facilitators to health promotion implementation.

### **2.6. Policy and Guideline Implementation**

The success of the smoking cessation strategy in the UK depends on the effective implementation of the smoking cessation guidelines, particularly within primary care. The following section of the literature review will therefore consider some of the issues around policy and guideline implementation, and reflect upon how these have relevance for the development and implementation of the smoking cessation services.

#### **2.6.1. The policy process**

There are different models of the policy implementation process. One model, which is linear, proposes that four main stages are involved: problem identification and recognition; policy formulation; policy implementation; and policy evaluation (Walt, 1994a). However, the extent to which this theoretical linear process represents reality is unclear. In contrast to the view that there is a direct linear relationship between policy formulation (goals) and policy implementation, the ‘bottom-up approach’ to the policy process proposes that those who implement policy also *inform* (and perhaps even constrain) policy. Specifically, this approach suggests that those who implement policy objectives at the local level, are more familiar with the local situation, and can therefore re-formulate policy objectives in an upward process (Walt, 1994b). The term ‘street-level bureaucrats’ has been used to denote this

influence of *local* actors in implementing policy objectives (Lipsky, 1971). As proposed by Walt (1994c), “*Policy-making is interactive, with formulation and implementation two elements in a continuous loop, and both as political as the other*” (p.156-157).

In considering the implementation of policy, therefore, it is important to consider the ‘top-down’ and ‘bottom-up’ influences on the policy process. With regards to the top-down processes, The Department of Health in England and the Scottish Executive Health Department issue advice and guidance about national priorities and strategies. Such guidance is usually disseminated through the likes of White Papers and subsequent focussed strategy documents such as NHS Circulars, the aim of which is to direct national priorities, which ideally should be incorporated into local agendas. However, the ‘Implementation Gap’ refers to how local interpretation of national policy may not necessarily match that advocated by the ‘Centre’ (Exworthy *et al.*, 2002).

In their extensive account of the policy implementation literature, Hill & Hupe (2002) outline the shift in emphasis that has occurred in this field of research. In particular, they embrace the shift from ‘misery research’ (Rothstein, 1998) that focuses on policy implementation failure (and offers little in the way of contributing to an understanding of the policy implementation process), to research that offers a greater theoretical and empirical means of delineating and researching the policy-action process. In reflecting upon recent advances in this field of literature, Hill & Hupe (2002) highlight several ‘independent variables’ that may impact upon the policy-action process. These variables range from characteristics of the actual policy and the local bodies implementing the policy, to wider organisational structures.

The remainder of this chapter will address some of the factors that have been highlighted in the literature as potentially mediating the policy implementation/policy-action process.

### 2.6.2. Changing roles and structures

Policy initiatives that threaten professional autonomy and/or existing roles and organisational structure may be more difficult to implement. Research by Goldie & Sheffield (2001) demonstrated the impact of ‘street-level bureaucracy’ following the dissemination of *Designed to Care* (The Scottish Office, 1998). *Designed to Care* outlined a new structural arrangement for the health service in Scotland. Broadly speaking, and with reference to primary care in particular, it signified a departure from GP fundholding by creating a stronger organisational structure to primary care, through the creation of Primary Care Trusts (PCTs) and Local Health Care Co-operatives (LHCCs). Specifically, PCTs assumed responsibility for funding primary care, through LHCCs – a collective organisation of GP practices, designed to deliver primary care services within defined geographical areas.

Goldie & Sheffield’s (2001) qualitative study investigated the barriers to implementation of *Designed to Care* across several Health Board areas, and found that there was resistance to the new roles, relationships, and structures required for the implementation of this new strategy. A couple of areas where tension was evident related to the reduction in main commissioning powers of GPs, and increased performance management of GPs, thus making them more accountable to both Primary Care Trusts and Health Boards. With regard to the former, there was particular tension around budget control. Most GPs included in Goldie & Sheffield’s study argued that LHCCs should have more control over the PCT budget, allowing for greater efficiency of resources, and a raising of standards of care (as witnessed during the period of GP fundholding). In relation to increased performance management, GPs were reported to feel somewhat threatened by this increased accountability to PCTs and Health Boards. Some GPs felt uncomfortable about the prospect of performance managing other colleagues, one reason being that did not sit comfortably with their “*professional principles of autonomy and self-regulation*” (Goldie & Sheffield, 2001, p.14).

Clearly, policy directives that are not congruent with existing organisational structures and roles, may not be fully embraced by those affected, subsequently



making it more difficult for a policy to be implemented successfully. The medical profession is a professional group that has significant influence within the health service. Given this profession's central position in the provision of services, it is well represented at all levels of NHS management (Ham, 1999a), subsequently bearing heavily on the policy process. Policy initiatives that threaten professional autonomy and/or existing roles and organisational structure are likely to be more difficult to implement. Indeed the authors of the above study (Goldie & Sheffield, 2001) proposed that if some of the structural/relationship difficulties highlighted in their research were not adequately addressed, then the continued support from GPs in the implementation of the strategy outlined in *Designed to Care* might come into question.

Given that the smoking cessation services in the UK are strongly focussed on primary care, the role of GPs in ensuring that these services are implemented as intended is paramount. The Thorax guidelines proposed that the crux of smoking cessation intervention in Primary Care would be to *Ask, Assess, Advise, Assist, and Arrange*. This would involve GPs asking about and recording their patient's smoking status at every opportunity and advising them on the benefits of quitting, assisting those smokers who want to quit, arranging a follow-up visit to monitor progress, and referring patients onto a specialist service if required. Therefore, the support of the medical profession in ensuring successful implementation of the smoking cessation strategy is clearly important. Additionally, as key 'gate-keeper's to activity within the general practice setting, it is important that GPs are engaged with the smoking cessation strategy. The evaluation of smoking cessation services in England highlighted that opposition from GPs was a significant stumbling block in the development of smoking cessation services within primary care (Coleman *et al.*, 2005; Adams *et al.*, 2000).

### **2.6.3. Inter-governmental relations**

The role of 'layers' of government, and the varying dimensions of the structural framework of policy implementation, have been gaining increasing prominence in the policy implementation literature. Stoker's (1991) research on the implementation

of Federal policy in the USA, highlighted that when there were several ‘layers’ of government involved in the implementation process, co-operation and inter-governmental collaboration was crucial. It has been suggested that the ‘implementation gap’ (i.e. the gap between policy and practice) may now be more pronounced, given recent policy developments that have altered the structure of the NHS (Exworthy *et al.*, 2002).

As noted previously, the White Paper *Designed to Care* (The Scottish Office, 1998), proposed a re-structuring of the NHS in Scotland. The implementation of national policy has become increasingly devolved to the local level through Primary Care Trusts and, more specifically, Local Health Care Co-operatives. In effect, there are several layers of influence in health care delivery in Scotland. The NHS structure has therefore become increasingly multi-layered, and ‘hollowed out’ (Jessop, 1994). Hence, the structural elements of the policy implementation path between the ‘Centre’ and local agencies has become increasingly more complex. As Ham (1999b) pointed out, “*These bodies do not simply carry out the Department’s [Department of Health] wishes [...] These bodies [e.g. PCTs, LHCCs] are semi-autonomous organisations who themselves engage in policy-making, and as such exercise a key influence over the implementation of central policies*” (p.160).

An appreciation of the ‘horizontal’ dimension of the policy implementation process has been becoming increasingly important (Hill & Hupe, 2002). One prominent conceptual framework that embraces this dimension is that proposed by Exworthy & Powell (2004). In an early research paper, Powell & Exworthy (2001) considered policy implementation within the framework of ‘policy streams’. It was proposed that successful strategy/policy implementation was more likely to occur when the three policy streams of ‘policy’ (i.e. policy aims and objectives that are clearly stated and transmitted), ‘process’ (i.e. means of achieving these policy aims) and ‘resources’ (i.e. funding) converged.

In moving beyond the consideration of just ‘policy’, Exworthy *et al.* (2002) went on to reflect upon the ‘spatial dimensions’ of policy implementation. In considering the



vertical dimension, Exworthy *et al.* (2002) applied Kingdon's (1984; 1995) framework of policy streams to explore how 'windows' for policy implementation can be opened at the local level. Kingdon's framework proposes that opportunities for policy implementation are created when "*policy 'windows' open (and close) by the coupling (or decoupling) of three 'streams': problems, politics, and policies*" (Exworthy *et al.*, 2002, p.83). Simply put, these streams refer to the highlighting of *problems/issues* in the likes of government strategy documents that are to be tackled, the *policies* put forward for tackling such issues, and the *politics* interacting with this (e.g. the wider political agenda and 'ways of working- such as Joined-up Government).

A more recent paper by Exworthy & Powell (2004), however, has fused previous research by these authors, and argues that it is important to consider not just the vertical dimension of policy implementation (centre-local), but also the congruence of policy and action between central government bodies (centre-centre) and local bodies (local-local). In essence, Exworthy & Powell (2004) propose that successful strategy/policy implementation is more likely to occur when the three policy streams of 'policy', 'process' and 'resources' are aligned across these dimensions. They propose that "*failure to connect these streams at each level may lead claims that policies are rhetorical*" (Exworthy & Powell, 2004, p.269).

Exworthy *et al.* (2002) and Exworthy & Powell (2004) reflected on their research that explored the extent to which the UK Government's policy for tackling health inequalities had made it onto local policy agendas. The research goes some way to revealing the complexities of the policy implementation process, highlighting a perceived incompatibility between what was being advocated nationally, and what could be achieved at the local level. The findings from this research are discussed in detail below. Whilst the 2002 and 2004 papers reflect on similar issues emanating from the research, Exworthy & Powell (2004) specifically discuss the research findings within their most recent framework (i.e. the alignment of policy streams across the three spatial dimensions).

Exworthy *et al.* (2002) discussed that the proposal of a national strategy to tackle health inequalities was welcomed at the local level. Specifically, case study interviewees expressed that the placement of health inequalities on the national political agenda allowed for local strategies to be developed further, given that the issue was perceived to have been ‘legitimised’ by the New Labour government. However, it was discussed that due to other more pressing national imperatives, such as reducing hospital waiting lists, the issue of health inequalities was losing ground in terms of remaining a high priority on the local policy agenda. In reflecting upon the vertical dimension of policy implementation, Exworthy & Powell (2004) discussed that national policy was largely not reflected in local policy/strategies. This incongruence in the ‘policy stream’ (in the vertical dimension) was linked to a perceived lack of joined-up-government at the centre (centre-centre dimension), whereby “*the policy stream emanating from government contained multiple priorities, only one of which was health inequalities*” (p. 272). Additionally, there was reported to be conflict in the policy stream at the local level (local-local), whereby local agencies held different priorities (Exworthy & Powell, 2004).

It has been proposed that “*The ways in which issues such as health inequalities are performance managed by the centre indicate the de facto priority that the centre places on the issue (thereby denoting its position on the national policy agenda), and can influence whether the issue remains on the local policy agenda*” (Exworthy *et al.*, 2002, p.88). However, Exworthy *et al.* (2002) discussed how the case studies revealed the performance management of issues such as waiting lists and emergency services, which then had to become local priorities. Compared to other issues, there was perceived to be less clear targets for the tackling of health inequalities, and significantly less redress from central government if this issue was less effectively addressed. This had the effect of pushing the health inequalities issue (‘policy’ stream) further down the list of local priorities (Exworthy *et al.*, 2002). The issues of policy ‘priorities’ and performance management were, however, also inextricably linked to the ‘resource’ stream. Exworthy & Powell (2004) discussed that when money for specific policy initiatives was not ring-fenced (e.g. health inequalities), such policies had to compete with more pressing ‘priorities’.

As discussed previously, the smoking cessation services in England are monitored much more closely than Scottish services, and from very early on, throughput targets were set for the smoking cessation services in England. There are however various potentially positive and negative impacts of targeting on service provision. For instance, there is the danger of priority being directed at activity that is easily measurable (Smith, 1991), which provides little incentive for those agencies already doing well (Akehurst *et al.*, 1991), and which discourages those unable to reach such targets (Robinson, 1989a,b). In relation to the issue of disadvantaged groups, it has been proposed that efforts are more likely to be directed at sections of society where 'results' are most likely to be gained (Elkan & Robinson, 1998). Specifically with regard to health inequalities, it has been argued that target-setting might have the effect of deepening the 'inverse care law', whereby efforts may be directed more at the advantaged sections of society, where results are most likely to be gained (Elkan & Robinson, 1998). Indeed, the evaluation of smoking cessation services in England highlighted that through-put targets had a detrimental impact upon the development of services to attract the three priority groups- young people; low-income; pregnant women (Pound *et al.*, 2005).

With regards to the 'process' stream, Exworthy *et al.* (2002) and Exworthy & Powell (2004) reported widespread dissatisfaction with the policies devised by Central Government to tackle health inequalities at the local level. Specifically, it was discussed that national policies did not account for local constraints upon policy implementation, and that policies were not always technically feasible. With regards to the vertical dimension, Exworthy & Powell (2004) discussed a lack of attention by central government to how health inequalities could be tackled locally, in light of the complex nature of the problem and the many other national priorities that were on the local agenda. There was disappointment with the lack of 'Joined-up Government' (JUG) (centre-centre). The term JUG is used to denote the government's push for greater partnership working, and more co-ordinated interdepartmental and interagency working (Powell *et al.*, 2001). However, there was discontent at the local level, where it was observed that this was lacking (Exworthy *et al.*, 2002).

Exworthy and Powell (2004) also reported difficulties in the process stream at the local level (local-local). A distinction was made between a “dedicated entity” (i.e. responsibility for policy implementation resides with a limited number of individuals or units) and a “diffuse approach” (i.e. policy accepted as part of the cultural ethos of an organisation). However, it was reported that health inequalities had been adopted as a ‘dedicated approach’ and “*were not seen as a ‘core activity’ across organizational departments*” (p.277-8). Thus, this rendered the implementation of health inequalities policy more difficult.

The theoretical framework presented by Exworthy & Powell (2004) therefore moves beyond the traditional vertical dimension of policy implementation to engender a more complex framework for reflecting upon the policy-action process. Specifically, they suggest that successful policy implementation requires alignment of the three policy streams (‘policy’, ‘process’ and ‘resources’) not only in the vertical dimension, but also at the centre (across central government departments) and at the local level.

#### **2.6.4. Contextual influences on policy implementation**

The role of ‘*context*’ has been receiving increasing attention in the literature. This is particularly apparent in the fields of innovation diffusion and organisational change, where context has been highlighted as a potentially crucial factor in mediating the policy implementation process. *Diffusion of Innovation Theory* (Rogers, 1983; 1995) describes the process through which an innovation diffuses into practice over time within a given “social system”. An “innovation” is described by Rogers as “*an idea that is perceived as new by an individual or other unit of adoption*” (Rogers, 1995, p.11). Early diffusion of innovation work was strongly centred around the adoption of innovations by *individuals*, although there have been significant theoretical developments in diffusion research. These have been underpinned by the recognition that a linear stage-like approach to diffusion is insufficient for capturing and explaining all elements of the diffusion process. One factor underpinning this theoretical shift has been the emergence and influence of *organisational* innovation research. Early diffusion models were concerned with the adoption of innovations

by individuals, and appeared to neglect the fact that such individuals often operated within an organisation of some sort. For instance a doctor works within a larger unit, such as a hospital, and not necessarily in isolation (Rogers, 1995). A research tradition has therefore emerged around the study of innovation diffusion within organisations. One aspect of this has been a focus on the '*absorptive capacity*' of 'receiving organisations', and hence their potential to integrate new working practices required for the successful adoption and implementation of an innovation (Fiol, 1996). The '*absorptive capacity*' has been described as encapsulating "...*the inner context of the organisation's boundary, the history, culture, and quality of interprofessional relationships...*" (Fitzgerald *et al.*, 2002, p.1446).

As a concept however, *context* has been defined in different ways in the literature, and there is a lack of consensus regarding its integral components. In a study by Abelson (2001), which investigated the role of context on local healthcare decision making in four different geographical communities, contextual influences were divided into three components. The first component was the *pre-disposing influences*, accounting for the structural and social aspects of the population, such as socio-economic, employment, cultural and religious characteristics. The second component was labelled *enabling influences*, which was defined as the 'institutional context for decision-making'. This accounted, for instance, for the role of Local Government, and whether or not it facilitated community participation in the local decision-making process. The final component was the *precipitating influences*, and this accounted for the impact that specific 'precipitants' could have on shaping community participation in healthcare decision-making. In Abelson's (2001) study, one specific 'precipitant' was addressed. This was the threat of local hospital closures, and the impact this had on drawing the local community into the decision-making process. This component therefore addressed the impact of the political climate. In other literature however, context has been defined in quite a different way.

McCormack *et al.* (2002) conducted a concept analysis of *context* as a variable in the implementation of evidence-based medicine, and defined *culture* as a key sub-

element of *context*. With regard to *culture*, this has been defined as the values and beliefs that underpin an organisation, and as Bate (1994) describes, “*Culture is not something that an organisation has but something an organisation is*” (p.12). In this respect, McCormack *et al.* (2002) considered culture to be an integral component of context, and defined it according to the clarity and consistency of an organisation’s values and beliefs in relation to, for instance, staff roles, teamwork, relationships, and learning orientations.

In the organisational change literature, seminal work by Pettigrew *et al.* (1992), has adopted a *contextualist perspective*. This highlights the crucial role that context can play in the process and management of strategic change in the NHS. The authors argue that much of the literature around organisational change is acontextual in nature. Similar to Fiol’s (1996) notion of the ‘absorptive capacity’, Pettigrew *et al.* (1992) consider an organisation’s *capacity* to change as an integral concept for their research. The ‘contextualist perspective’ sees context as shaping change, whereby it constitutes a crucial link between the *Content* of change (i.e. the particular idea/innovation/policy under study), and the *Process* of change (i.e. how change comes about).

Pettigrew *et al.* (1992) further delineate the concept of *Context*, and distinguish between the *inner* and *outer* contexts. The former relates to the context of the organisation under study (e.g. Health Board), and the internal structures, culture, management, and political processes. The latter however refers to the wider national, social, economic, and political context, which can have indirect effects on the inner context. In the same way that research can lend itself towards qualitative or quantitative methodologies, and hence a particular way of looking at and approaching data, the authors appear to see the contextualist *perspective* as a way of looking at the data, and not as an organising theoretical framework. In their study of the management of strategic service changes in the NHS between 1986 and 1990, as a result of the top-down re-structuring that occurred at this time, Pettigrew *et al.* (1992) conducted an in-depth analysis of the ‘change process’ over time within different Districts (*District Health Authorities*).



One of the key results from this research was that the pace and process of change differed between these Districts. In an effort to conceptualise the factors underpinning this, the authors describe a model around '*receptive contexts for change*'. This model includes a set of eight 'features of receptivity', believed to facilitate change, some or all of which may be present within a given organisation:- the quality and coherence of policy generated at the local level; long term environmental pressure; availability of key people leading change; effective managerial-clinical relations; co-operative inter-organisational networks; simplicity and clarity of goals and priorities; the fit between the District's change agenda and its Locale; and a supportive organisational culture. With regard to the latter feature, culture is again highlighted as an important element of context. Pettigrew *et al.* (1992) describe this concept as "*deep rooted assumptions and values far below surface manifestations [...] officially espoused ideologies, or even patterns of behaviour*" (p.281). A couple of the features of culture that were shown to be important included flexible working across boundaries, and where there was a focus on 'skills', as opposed to just rank or status.

In the diffusion of innovation literature, *primary care* has been described as a unique *context* in its own right, possessing characteristics that differ from that of the acute sector (Fitzgerald *et al.*, 2003; Fitzgerald *et al.*, 2002). Specifically, Fitzgerald *et al.* (2003) and Fitzgerald *et al.* (2002) describe the historical structure of primary care, with the independent GP practice constituting the core of this structure, with little tradition of inter-practice collaboration. Additionally, Fitzgerald *et al.* (2003) describe primary care as constituting a *network*, as opposed to a *hierarchy*, structure (although there can be a hierarchy between professions within general practice), describing one of the key features of this network as the delivery of services through co-ordination of staff and effort across the board. In primary care, this would involve collaboration between various organisations (i.e. General Practice; health visiting; district nursing; pharmacy; and other allied health professionals). Given the unique context of primary care, Fitzgerald *et al.* (2003) and Fitzgerald *et al.* (2002), consider the diffusion of healthcare innovations to take a different form from that of the acute

sector, where there is greater organisational *hierarchy*, and is a much more complex organisation.

Fitzgerald *et al.* (2003) and Fitzgerald *et al.* (2002), therefore identify the 'organisation' (e.g. primary care) as a key factor mediating the process of strategy implementation/diffusion. In a critique of organisational innovation research, Wolfe (1994) also identified 'organisational context' as a key variable impacting upon innovation diffusion. Wolfe (1994) made reference to the work of Evan & Black (1967) to propose that the case for accounting for 'organisational' type when considering the process of innovation diffusion, is still highly relevant today:

*"Without comparative research on the innovation process in various types of organizations, we can only speculate about the generalizability of elements of the innovation process" (Evan & Black, 1967, p.520).*

In addition to organisational context, Wolfe (1994) also highlighted the importance of acknowledging the characteristics of the *innovation*, whereby the "*determinants of innovation diffusion, implementation, and process differ as the characteristics of innovations differ*" (p.417). A key recommendation of Wolfe critique was that by reflecting upon the interaction between innovation attributes/characteristics and the organisational context, this would increase the generalisability of research findings. With regards to this PhD research, the smoking cessation services were to be implemented in primary care. Wolfe's critique suggests, therefore, that it considering the process of smoking cessation service development, it would be important to consider both the characteristics of primary care, and characteristics of the innovation (NHS smoking cessation strategy).

#### **2.6.5. Implementation of evidence and guidelines into clinical practice**

The previous section considered the implementation of policy at the wider organisational level. However, it is also important to consider influences at the individual health practitioner level. The successful implementation of the smoking cessation services requires that the guidelines are implemented in day-to-day



practice. For instance, those in first contact with patients have the role of providing the brief interventions, and ensuring that patients are referred on for specialist support if required. In most cases it will be General Practitioners who act as the first point of contact for patients. However, the literature suggests that the implementation of guidelines in day-to-day practice is not necessarily a simple or linear process.

#### ***2.6.5.1. Diffusion of Innovation literature***

Some researchers have drawn on the Diffusion of Innovation Theory (Rogers, 1983) to describe how new clinical behaviours (*innovations*) may be adopted by healthcare professionals and diffused into practice (Sanson-Fisher, 2004; Stocking, 1992). In this respect, the model is applied to understand diffusion of innovation at the *individual* level, and not within organisations. The diffusion of innovation model (Rogers, 1983; 1995) proposes that there are five proposed characteristics of an innovation that, in addition to other factors, may facilitate its adoption. These are: *relative advantage* (whether the innovation is perceived as better than the one it supersedes); *compatibility* (the extent to which the innovation is compatible with the values and requirements of the adopters); *complexity* (whether the innovation is perceived as difficult to implement); *trialability* (extent to which the innovation can be ‘trialed’ for usefulness/success); and *observability* (the degree to which the effects of the innovation are visible to others- which, if successful, could encourage further adoption).

The previous section discussed recent research on innovation diffusion in healthcare *organisations* (Fitzgerald *et al.*, 2003), and highlighted the role of context on the diffusion process, specifically, the idiosyncrasies of the primary and acute care sectors. However, with regard to how evidence and guidelines may be specifically integrated into clinical practice, Fitzgerald *et al.* (2003) also highlighted the process through which healthcare professionals assess and implement ‘evidence’. This research focussed on four innovations, two of which were based on strong scientific evidence, and the other two on a weaker evidence base. The key finding indicated that the *credibility* of the evidence was not necessarily enough to ensure that it was

implemented into working practice. Three factors appeared to mediate this process. One, GPs felt that the evidence was not entirely relevant to primary care, particularly as it was based on RCT data from the acute sector. Secondly, it was not only the strength of the evidence base that was important, but also its *source*. Establishing a consensus around credibility and relevance to professional practice through networking and inter-professional relationships was also perceived as important. Finally, health professionals considered a range of factors beyond the evidence-base for the use of an intervention, including the impact of the intervention on the patient in terms of side effects and satisfaction, financial considerations, and the complexity of the medical regime- specifically in terms of patient compliance. Fitzgerald *et al.* (2003) found that the use of aspirin for the prevention of secondary cardiac events was one intervention that was weighed positively in light of the above criteria. Subsequently, aspirin was found to be implemented more widely in professional practice.

Another finding from this research (Fitzgerald *et al.*, 2003), was the influence of *opinion leaders* in the innovation diffusion process. Opinion leaders have been defined by Locock *et al.* (2001) as “*those perceived as having influence on the beliefs and actions of their colleagues in any direction, whether ‘positive’ (in the eyes of those trying to achieve change) or ‘negative’*” (p.746). However, Locock *et al.* (2001) acknowledge that a precise definition of an ‘opinion leader’ is particularly difficult to establish given their subjective range of influence within different settings.

In an evaluation of two initiatives exploring the implementation of research evidence into clinical practice, Locock *et al.* (2001) distinguished between the impact of *expert* and *peer* opinion leaders in partially mediating this process. The former was viewed as a ‘credible authority’ who in essence provided the professional/expert endorsement for the diffusion of a given innovation. The latter on the other hand, although not necessarily an expert, was able to influence innovation diffusion by being a source of reference for their peer group. In particular, this person was someone that other people trusted and could identify with. An example of this *peer*

influence process is highlighted in research by Fairhurst & Huby (1998), which examined how GPs applied evidence around the management of hypercholesterolaemia through statin drugs. It was found that local guidelines produced by people known to the GPs in this study were more likely to be adhered to than national guidelines written by experts in the field.

Fitzgerald *et al.* (2003) highlighted the social and interactive nature of the diffusion process in the healthcare setting, and the information exchange that takes place within professional networks- identifying the influence of a 'credible, local professional' in the diffusion process. One example taken from this research (Fitzgerald *et al.*, 2003), was the influence that one GP had in leading an innovation for the use of HRT for the prevention of osteoporosis. This particular GP had a background in family planning training, and was a key source of influence in the adoption of this innovation amongst partners, through information sharing and initiating changes in practice. The influence of opinion leaders closely resembles the role of 'key people leading change', as outlined in the organisation change research by (Pettigrew *et al.*, 1992), which demonstrated that key people could act as strong influences in the innovation diffusion process. However, as highlighted by Locock *et al.* (2001), it is also important to consider the interplay between opinion leaders and the local contexts within which they operate. Locock *et al.* highlight the role of context in impacting upon the *type* and *function* of opinion leaders that may emerge. For instance, a traditionally innovative District or general practice may be more receptive to the influence of an opinion leader trying to effect change.

#### ***2.6.5.2. Evidence-based practice literature***

There is a plethora of literature around evidence-based practice and guideline implementation in the healthcare sector, particularly within the context of primary care and general practice. This literature has highlighted a wide range of factors that may mediate the implementation process. A systematic review by Cabana *et al.* (1999) of guideline implementation literature found that barriers to guideline adherence in clinical practice could be categorised according to clinicians' *knowledge*, *attitudes*, and *behaviour*. With regard to *knowledge*, a lack of familiarity

and awareness of guidelines were found to be prominent barriers. *Attitudes* towards guidelines were also found to be important, encompassing clinicians' views around outcome expectancy (will guidelines have desired effect?), self-efficacy (belief in ability to implement guidelines), and motivation (inertia of routine practice). Agreement with guidelines was also crucial, both in general and specific terms. With regard to the former, negative views of guidelines could be a barrier to implementation, particularly concerning their "cookbook" nature, and the potential challenge to professional autonomy. In terms of attitudes towards *specific* guidelines, this resonates strongly with the findings from the diffusion of innovation study outlined previously by Fitzgerald *et al.* (2003). Specifically, guidelines could be interpreted according to the evidence base, their applicability to patients, financial considerations, and trust in the guideline developer. Finally, in terms of the *behaviour* component, a range of potential barriers were identified by Fitzgerald *et al.* (2003), including individual patient factors and preferences, a lack of time and resources, and organisational constraints.

Other literature has re-iterated the importance, and prevalence, of these barriers. Sackett *et al.* (1997) highlighted four common "misconceptions" around guidelines. These were that they only emphasise what it already done in clinical practice; they may act as a substitute for clinical judgement; there may be a lack of time to implement guidelines; and as identified by Cabana *et al.* (1999), the perception that they will lead to "cookbook" medicine. With regard to a 'lack of time', this has been highlighted elsewhere. For instance high workloads, and the perception that guidelines may lead to more paperwork, has been cited as one potential barrier to guideline implementation amongst primary health care professionals (Powell-Cope *et al.*, 2004). Similarly, in a review of CHD guideline adherence amongst primary care physicians across five European countries, time constraints were found to be the largest barrier (Hobbs & Erhardt, 2002). This was found to be particularly so in the UK, due to high consultation rates (Hobbs & Erhardt, 2002). The term 'cookbook' medicine was referred to previously by Cabana *et al.* (1999), and suggests that health professionals may perceive guidelines as undermining professional autonomy over clinical decisions, and as overlooking the idiosyncratic nature of the patient context.

Indeed, in a study of GPs, Dowsell *et al.* (2001) found that around half of the GPs in the study felt that clinical guidelines reduced the autonomy of the doctor, and overlooked patient context. Similarly, Michie *et al.* (2004) found that GPs were aware of the difficulties involved in applying guidelines that are based on population research to the individual patient. Given their prominence in the literature, I will now consider the two issues of conflict with patient-centred medicine and reduced clinical autonomy in more depth.

### ***Guidelines and Clinical Autonomy***

In previous sections of this literature review, the prominence of the medical profession was highlighted. This related to discussions around policy implementation, and the implementation of health promotion practice into primary care. The medical profession has traditionally enjoyed a considerable degree of autonomy (Dopson *et al.*, 2003). With the increasing use of guidelines in clinical practice, recent literature has highlighted the tension between such guidelines and the desire for the medical profession to exercise clinical autonomy (Michie *et al.*, 2004; Dopson *et al.*, 2003; Armstrong, 2002; Langley *et al.*, 1998; Geddes & Harrison, 1997; Feinstein & Horowitz, 1997). The qualitative study by Michie *et al.* (2004), investigating the achievement of National Service Frameworks (NSF) for coronary heart disease in primary care, also found perceived lack of professional autonomy to be one key factor distinguishing low and high implementers of the NSF milestones. In this study, low implementers were more likely to consider the use of guidelines as undermining a doctor's license to make independent judgements around clinical practice. Langley *et al.* (1998) found that GPs viewed guidelines as just that, and not as definitive rules for clinical practice. In this research, Langley *et al.* (1998) described the struggle between the desire of GPs to maintain clinical autonomy, and the increasing pressure towards standardisation of clinical services through measures such as guidelines.

### ***Conflict with patient-centred medicine***

The implementation of evidence-based practice is not a straight-forward process, and guidelines may be implemented in the context of the doctor-patient relationship.

Research suggests that clinical guidelines may fall into conflict with a patient-centred approach. For instance, in a qualitative study by Mayer & Piterman (1999), a sample of Australian GPs felt that evidence-based medicine and guidelines were based on quantitative research, and did not adequately account for the integral psychosocial aspect of medical practice. This appears to be a common area of concern for GPs. In a qualitative study of the implementation of hypertension guidelines amongst elderly patients, it was found that most GPs did not consider the guidelines to be compatible with the treatment of their elderly patients (Cranney *et al.*, 2001). This view was embedded within the perceived complexities of elderly patient care. This included the fear of side effects, poor medication compliance amongst this patient group, and the perceived importance of monitoring hypertension (i.e. blood pressure) in light of other more serious conditions such as dementia.

Previously in this literature review it was discussed that GPs were often more comfortable with their secondary prevention role, in terms of treating illness as opposed to preventing it. However, even in their secondary prevention role, GPs may experience personal conflict around implementing evidence-based medicine in practice. One key finding from a qualitative study exploring the management of CHD through secondary prevention in general practice, found that the implementation of evidence-based medicine often came into conflict with maintaining a positive doctor-patient relationship (Summerskill & Pope, 2002). Decisions to implement secondary prevention strategies often had to be centred around the patient's personal situation. This included difficult personal circumstances, a perceived ability of the patient to adhere to more complicated medical regimes, and the need to ensure that patients were comfortable with their medical regime. In essence, it was not always perceived to be appropriate to implement clinical guidelines in practice.

The doctor-patient relationship is an integral part of medical care, and one perceived difficulty with the implementation of evidence-based practice is the possibility of jeopardising this relationship (Veldhuis *et al.*, 1998). An in-depth qualitative study looking at the implementation of evidence-based practice amongst GPs, found that



evidence was interpreted within the context of the patient's unique circumstances, as well as a reciprocal doctor-patient relationship (Freeman & Sweeney, 2001). The doctor-patient relationship has also been perceived to be challenged by top-down pressures to implement evidence-based practice through measures such as National Service Framework (NSF) milestones (Michie *et al.*, 2004). In addition to being aware of the difficulties involved in applying guidelines that were based on population research to the individual patient, Michie *et al.* found that a perceived undermining of the traditional doctor-patient relationship was one key factor distinguishing 'low implementers' (in terms of meeting milestones) from the 'high implementers'.

With regard to smoking cessation advice in general practice, Butler *et al.* (1998) found that the doctor-patient relationship could potentially be harmed by the provision of anti-smoking advice by GPs in a consultation. This qualitative study investigated patients' perceptions of their GP's quit-smoking advice. A particularly negative response was found amongst two specific categories of smokers. The first category was the "contrary" group, defined by Butler *et al.* as those patients who expected GPs to bring up smoking in the consultation, were less convinced of the benefits of quitting, and who tended to smoke more when challenged. The second category of smokers was the "self blaming" group, defined as those who were ashamed of their smoking, were aware of the health-damaging effects, and felt personal failure upon not being able to give up. In light of these findings, Butler *et al.* (1998) highlighted the potential damaging effects of opportunistic health promotion on the doctor-patient relationship. Indeed, in a qualitative study of GPs that looked at the factors mediating the discussion of smoking between GPs and their patients, it was found that GPs were keen to maintain a good doctor-patient relationship, and decisions to discuss smoking were centred around this (Coleman *et al.*, 2000). Consequently, GPs in this study preferred to raise the issue of smoking when the patient presented with a smoking-related illness, or where there was an existing positive doctor-patient relationship.



This section (2.6.) has provided an overview of some of the key literature around policy and guideline implementation in the health service. It first of all provided a perspective on the wider issues around policy implementation, and then considered the more the more intricate issues around evidence-based practice and the implementation of guidelines into clinical practice.

## **2.7. Chapter summary**

The literature review has provided the following:

- 1.** A background to *Smoking Kills*, by outlining the key issues around UK health policy that have been gaining increasing prominence.
- 2.** An outline of the the smoking cessation guidelines and Governmental guidance underpinning the implementation of smoking cessation services in the UK.
- 3.** Highlighted the main findings from the evaluation of smoking cessation services in England that are pertinent to this thesis.
- 4.** Highlighted key issues from the literature on health promotion in primary care, and policy and guideline implementation in the health service.

# CHAPTER THREE

## Methodology

This chapter, which discusses the process involved in conducting the research, has seven sections. It begins by outlining the research proposal, key research questions, and key methodological approach to the research. I then discuss the steps taken to familiarise myself with the research topic, including informal discussions and literature reviews. The research design is then outlined, which details the conceptual structure underpinning my research, and my decision to adopt a case-study approach. I then outline the main steps involved in gathering the data, including the development of my interview guide, sampling and access. This is followed by a reflection on the interviews, including a reflexive analysis. I then consider the key ethical issues underpinning the research, focusing on the areas of *consent* and *anonymity*. The final section of the chapter focuses on how the data was analysed.

### 3.1. Outline of Research

#### 3.1.1. Research proposal

The research proposal for this PhD was submitted by my supervisors at the University to The Chief Scientists Office (CSO) at the Scottish Executive, prior to me undertaking the research. The research topic, and *general* research questions and methodology were therefore pre-determined. The funding subsequently awarded to the study indicated that it was considered by The Scottish Executive to be a valuable and timely topic for research.

#### 3.1.2. Research Questions

1. What smoking cessation services have been developed and delivered by each of the LHCCs (or LHCC equivalents) within the Health Board?

2. What are participants' perceptions of the factors that have influenced the development and delivery of the smoking cessation services within each LHCC (or LHCC equivalent)?
3. What are participants' perceptions of the issues around the evaluation of the smoking cessation services?
4. What are the implications for the long-term sustainability of these smoking cessation services?

The original research proposal stipulated that two rounds of interviews would be conducted with key stakeholders involved in the development, delivery and evaluation of the smoking cessation services within the given Health Board. It was expected that the first round of interviews would address research questions one to three, whilst the second round of interviews would address research question four. However, as will be discussed later in this chapter, only one round of interviews was conducted. These interviews were deemed sufficient to address all of the four research questions.

### **3.1.3. Methodological approach**

This study uses a qualitative approach. Qualitative and quantitative approaches have emerged from contrasting research paradigms, and the assumptions underpinning their approaches to research and inquiry are therefore quite different. Stake (1995) has outlined three major differences between qualitative and quantitative approaches, which provides a useful framework for understanding the two approaches and their application.

The first difference relates to the ontological perspective (nature of 'reality') underpinning these approaches, and the differential focus on knowledge that is *discovered* versus knowledge that is *constructed* (Stake, 1995). Quantitative approaches and positivist paradigms focus on the 'discovery' of objective 'knowledge'/reality. Qualitative approaches, however, commonly subscribe to the view that knowledge is 'constructed' through experience, and therefore no one 'objective' reality can exist (Guba & Lincoln, 1998; Stake, 1995). Constructivism is

an inquiry paradigm that understands knowledge as ‘constructed’ from our experience of the world, our interactions with our environments, and the societal and cultural frameworks within which we operate (Guba & Lincoln, 1998; Stake, 1995). The aim of research, therefore, would not be to establish an objective reality, but to reach the clearest understanding by drawing on the differentially constructed knowledge of respondents (Stake, 1995).

Secondly, Stake defines the purpose of quantitative research as focusing on *explanation*, whilst qualitative research focuses on *understanding*. Quantitative research is associated with establishing ‘cause and effect’ relationships, whereby context and unique cases are eliminated/controlled in order to establish broad generalisations (Stake, 1995). One critique of the quantitative approach, however, is that such “context stripping” (Guba & Lincoln, 1998, p.197) underplays the importance of context and the impact it could have on mediating, and applying, research findings. Qualitative research, however, is concerned with generating understandings of phenomena that are based on data that is contextually grounded (Mason, 1996) and reflects the unique aspects of individual cases (Stake, 1995).

The epistemological stance underpinning these approaches, therefore, in terms of how knowledge is created and demonstrated (Mason, 1996), is quite different. Quantitative research would commonly create and demonstrate knowledge/reality via quantitative data collection methods (i.e. surveys, experiments) and measurements (e.g. significance of ‘cause and effect’ relationships). Qualitative research, on the other hand, is ‘interpretivist’ (Mason, 1996), whereby an understanding of social phenomena is achieved through respondents’ accounts and interpretations of key events (Stake, 1995). However, central to qualitative research, is the subjective and active role of the researcher in the ‘creation’ of research findings, which leads onto Stake’s final distinction.

Quantitative research defines the role of the researcher as that of an objective inquirer, whereby efforts are made to eliminate extraneous influences and personal bias/values from the research process and, therefore, research findings (Guba &

Lincoln, 1998; Stake, 1995). Qualitative research, however, is underpinned by the assumption that research findings can be created through an interaction between the researcher and the researched - e.g. people/respondents (Guba & Lincoln, 1998; Stake, 1995). Specifically, in qualitative research, the researcher, as interpreter, commonly plays an active role in guiding the research process in accordance with emerging issues/theories. The emergence and investigation of *emic* issues (issues that emerge as important to research respondents, but were not identified as key issues prior to initiating the research), for instance, is an important component of researcher/respondent interaction (Stake, 1995).

Qualitative research, therefore, allows for the exploration and understanding of contextual and experiential phenomena, and can be employed as useful means of complimenting quantitative research (Pope & Mays, 1995). Qualitative research, for instance, is commonly used in health services research as it allows for the in-depth exploration of issues that are less amenable to quantitative enquiry. For example, it can be used to explore individuals' perceptions of a range of issues such as health *beliefs* (Pope & Mays, 1995). Qualitative research is also particularly useful where little is previously known about a given field of study (Pope & Mays, 1995). Pope and Mays define the goal of qualitative research as:

*"...the development of concepts which help us to understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences, and views of all the participants". (p.42)*

The research questions set out in this study lent themselves to a qualitative approach. That is, the research set out to examine in depth participant perceptions about the development of smoking cessation services in one Health Board area. Specifically, I was keen to generate the accounts of key stakeholders involved in the development, delivery, and evaluation of these services.

## **3.2. Familiarisation with the research topic**

### **3.2.1 Reviewing the smoking cessation literature**

Upon starting the PhD, I had no previous knowledge of the policy literature surrounding the development and implementation of the new smoking cessation services, what kind of services had been developed in Scotland, or what the key policy/local issues were around service provision. I therefore felt the need to trace the development of smoking cessation service implementation in the UK. I used the White Paper 'Smoking Kills' as a starting point for this process. My supervisors also introduced to me, at this early stage, to important avenues for pursuing my background research. Specifically, I was encouraged to make contact with ASH Scotland (Action on Smoking and Health), an important information source for tobacco control issues in Scotland. I also joined the Globalink internet network in order to keep informed about wider tobacco control strategies within the UK and beyond.

I found connections with ASH Scotland particularly useful in the early stages of my research. Their information resources pointed me in the direction of many of the key policy documents that had been published since the 1998 White Paper. From these documents I was able to compile a literature review that gave me a solid grounding for understanding the key stages in the development of the smoking cessation services in the UK since the White Paper. However, at this stage I was conscious of the fact that I had no specific *contextual* information regarding the specific issues surrounding implementation of the services in Scotland. Published evaluations and papers at that stage were concerned only with the English services (these services had been set-up one year in advance of those in Scotland). In order to obtain this contextual information, I felt it necessary to start holding informal meetings with people who were involved with the services in some way in Scotland.

### **3.2.2. Informal meetings**

I was sent an unexpected introductory email about a month into my research from the smoking cessation co-ordinator for the Health Board under study in the research.

This email invited me to contact her when I felt ready to do so. She had heard about my research through a contact at ASH Scotland. I had concerns that the co-ordinator might be annoyed that I had not contacted her to inform her of the research which I intended to carry out on her 'patch'. I therefore arranged a meeting to discuss my research with her in more depth. This meeting was held a few months into my PhD. Following this meeting the co-ordinator for the Health Board invited me to a quarterly smoking cessation meeting at the Health Board, where I first met (albeit briefly) with the Development Managers for all the LHCCs in the Health Board.

Around this time I also arranged to meet with the Scottish Tobacco Control Alliance (STCA) Co-ordinator at ASH Scotland, and the Information and Resource Officer. These contacts were able to provide me with the policy and practice background with regard to smoking cessation service development in Scotland. I also met with smoking cessation co-ordinators from two other Health Boards in Scotland, and a senior academic involved in the evaluation of the smoking cessation services in England. These meetings largely came about through the contacts I made. That is, I made many contacts through a process of snowballing, and also, in one instance, through an introduction at an academic seminar.

Coming fresh to the topic area, I relied on taking advice from those working in the field (including my supervisors) to point me in the direction of the sources that they felt would be useful and informative. Indeed, by the end of this preliminary data gathering stage (literature and 'fieldwork'), I had made important contacts with key people at an early stage in my research. This provided me with a solid grounding for commencing my formal fieldwork at a later date. Furthermore, I felt I had gained an adequate understanding of the structure and operation of the services both in England *and* Scotland. I was in a more knowledgeable position, therefore, to draw out important issues that should be explored further in my formal interviews. Additionally, I was in a much stronger position for locating the experience of the Health Board under study within a wider Scottish and UK context.



### **3.2.3. Literature Reviews**

Following on from this ‘familiarisation’ phase, I carried out further reviews of the literature. These reviews were informed primarily from information gained from the key contacts. These contacts had highlighted for me salient issues around policy implementation, for instance the role of key LHCC staff in mediating the speed and form of smoking cessation service development. This led me to consider policy development and implementation issues in the National Health Service more generally. This literature review helped to me to locate some of the issues that had been raised in discussions with contacts, and also highlighted other areas that I could consider exploring in the formal interviews.

I then carried out a literature review on the area of health promotion practice in primary care. This was important for the PhD study because it formed the broad focus of the research. Here, I was keen to explore how the issues highlighted around smoking cessation service implementation - as a health promotion initiative- corresponded with the wider literature. As with the previous literature review, I also hoped to generate salient issues for exploration at the formal fieldwork stage.

By the end of this ‘familiarisation’ stage, I felt confident enough to move onto considering my research design. The literature reviews and preparatory fieldwork had given me a solid grounding for understanding and articulating the issues that I wanted my research to focus on, and how this might best be achieved. At this stage, I was in a position to consider the initial research proposal in more depth, taking into account my preparatory work and my thoughts about how best to proceed with the research.

## **3.3. Research Design**

### **3.3.1. Conceptual Structure**

To reiterate, an initial research proposal was developed prior to me undertaking the research. However, after conducting the preliminary literature and fieldwork, it was necessary for me to return to the proposal, and consider how the original aims

resonated with my developing ideas about the research. This was an important task because the aims and broad research questions would form the conceptual framework for my research. This conceptual framework would subsequently provide a boundary within which deeper research questions could be framed, and research findings could be interpreted. It was therefore crucial that it was appropriately defined early on:

*“The design of all research requires conceptual organization, ideas to express needed understanding, conceptual bridges from what is already known, cognitive structures to guide data gathering, and outlines for presenting interpretations to others” (Stake, 1995, p.15).*

The original proposal outlined four conceptual strands, which were the factors involved in/issues around the *development, delivery, evaluation, and sustainability* of smoking cessation services. These four concepts loosely guided the focus of my informal discussions in the early stages of my research, and I found them to be useful guides for enquiry and focussing discussion. Furthermore, it was also clear to me that not only were they *useful* guides, but they represented important elements of the research topic. In other words, upon holding informal discussions with some key people involved in the services in Scotland, these concepts appeared to be salient areas of interest. Additionally, they represented the natural focus and flow of discussion around smoking cessation service development and implementation. Therefore, upon reviewing the original research proposal, I was keen to maintain these conceptual strands as focal points for my study.

### **3.3.2. Ontology and epistemology**

Within the broader qualitative paradigm there are several different traditions within which researchers work. The particular approach taken will reflect the researcher’s ontological and epistemological position. Issues of ontology and epistemology have been described as underpinning the research design process in the following way:

*“A student’s methodology is driven by certain **ontological and epistemological assumptions** and consists of **research questions or hypotheses, a conceptual approach to the topic, the methods to be used in the study- and their justification-***

*and, consequently, the data sources. All of these components are inextricably linked to one another in a logical manner”* (Grix, 2001, p.36, Emphasis added).

To reiterate, ‘constructivism’ is an inquiry paradigm that understands knowledge as ‘constructed’ from our experience of the world (Guba & Lincoln, 1998; Stake, 1995). Whereas those working within *positivist* paradigms assume a ‘true’ and ‘objective’ reality, constructivists understand ‘reality’ as constructed through our experiences (Guba & Lincoln, 1998; Stake, 1995). Central to the concept of ‘constructivism’, therefore, is the recognition that *“no aspects of knowledge are purely of the external world, devoid of human construction”* (Stake, 1995, p.100).

This study was informed by constructivist principles to the extent that its aim was not to establish an objective reality, but to reach the clearest understanding possible from respondents’ differentially constructed knowledge (Stake, 1995). The findings of the study derived from individuals’ perceptions and experiences of smoking cessation service development. From the study outset I became increasingly aware that these perceptions would differ between individuals according to their different experiences and informed by the contexts within which they worked. For example, I was aware that accounts may differ depending on the specific working context of an LHCC, the position that people held (e.g. strategic versus delivery roles), and their general commitment to/interest in smoking cessation as a health promotion activity.

Issues of epistemology are also important to clarify because they indicate the researcher’s position in relation to the creation and demonstration of ‘knowledge’ (Mason, 1996). To reiterate, within qualitative research, knowledge is understood to be created through the interaction between the researcher and the research respondents (Guba & Lincoln, 1998). This is quite different to epistemological understandings that index quantitative research. Those working within positivist traditions understand knowledge to be an ‘objective’ entity, and all efforts are made (through the research techniques and tools) to avoid the subjective understandings of the researcher entering into the research process.

Within qualitative research, where knowledge is understood to be created through interaction, one researcher-respondent relationship, may therefore be very different from another. This may result in different questions being asked and different responses being generated (Finlay, 2002). Reflexivity is an important aspect of qualitative research because it recognises the researcher's role in the creation of data:

*"The researcher should constantly take stock of their actions and their role in the research process, and subject these to the same critical scrutiny as the rest of their 'data'. This is based on the belief that a researcher cannot be neutral, or objective, or detached, from the knowledge and evidence they are generating. Instead, they should seek to understand their role in that process"* (Mason, 1996, p.5-6).

A reflexive account of the research process is presented throughout this chapter. However, two decisions were made early on in the research process that were crucial in shaping the type of knowledge generated from the research. These issues were (a) the type of professionals I wished to interview, and (b) the research questions underpinning the thesis. These are discussed below.

First, in order for my research to produce informed knowledge around the process of smoking cessation service development (and the main issues involved), it was important that key respondents were involved in the research. These respondents would include: individuals in a service development role (primarily 'strategic' role); those in a service delivery role; and also those who could provide a strategic overview of smoking cessation service development more generally. By involving a wide range of respondents in the research, it was expected that the knowledge/data produced would represent an account of the service development process that reflected a broad range of views. Had the research included, for example, service delivery staff only, it would have likely generated a more limited (although equally true/valid) account (Guba & Lincoln, 1998). It is noted however that decisions about sampling were not all made at the beginning of the study. They were also informed, later in the research, through the interaction between myself and respondents' accounts of the process of smoking cessation service development. This issue is discussed further in section 3.5.2.

Secondly, from the outset the research was guided by a broad conceptual framework, within which I identified key issues to be explored. However, I recognised that emic issues (Stake, 1995) pertinent to the respondent may also emerge through interaction and could be integrated into the conceptual framework. In section 3.5.2. I outline the circumstances whereby emic issues were identified, and subsequently informed the consideration of new ‘issues’ to explore within my research. These emic issues were crucial for advancing the focus of my research (in terms of research questions), and, therefore, important in informing the parameters for knowledge construction.

### **3.3.3. Method of data collection**

The original research proposal stated that the study would be qualitative in nature, and that interviews would be the primary means of data collection. Upon reviewing the research proposal following my preparatory work, I considered this approach to be appropriate. As outlined above, I was keen to generate accounts of experiences around, and reflections upon, the development and implementation of smoking cessation services. The constructivist paradigm defines that ‘knowledge’ (i.e. data) is generated via a dialectical process between the researcher and the respondents, whereby constructions are explored (Guba & Lincoln, 1998). Other ways of tracing such a process, such as through official documentation (minutes of meetings; primary care reports), would not have provided me the contextual and experiential reflections on such processes.

There were two key reasons why an alternative qualitative data gathering method, such as focus groups, was not chosen. Firstly, I was aware that some of the people I would be interviewing would be in positions of ‘power’. I felt the one-to-one approach of the interview, therefore, would encourage the interviewees to feel that they could express more than they perhaps would in company of their peers. Secondly, it became clear to me during my ‘familiarisation’ stage that there would be only a select number of key people who could offer me the type of in-depth data that I would require. It was entirely feasible, therefore, (time-wise) to conduct individual interviews. I chose to conduct semi-structured interviews, using an interview guide. It has been suggested that semi-structured interviews are more effective than

unstructured, or overly structured, interviews when research involves ‘elites’. Specifically, in semi-structured interviews power still resides with the researcher, thus ensuring that key research questions are addressed (Walford, 1994; Ostrander, 1995; Hirsch, 1995).

To re-iterate, I felt it was necessary to interview those key people who were involved in both the development (strategic; advisory) *and* delivery of the smoking cessation services. Both *development* and *delivery* constituted two of the broad conceptual strands of my study, and I therefore felt it was crucial to obtain representations from people involved in each aspect of service provision. This would allow for experiences that were couched in different levels of involvement to come through in my research.

#### **3.3.4. A Case Study Approach**

This research adopted a case-study approach. The case study approach has been defined as being particularly compatible with the study of *process* (Becker, 1966). As outlined by Yin (1984):

*“ ‘How’ and ‘why’ questions are more explanatory and likely lead to the use of case studies, histories, and experiments as the preferred research strategies. This is because such questions deal with operational links needing to be traced over time, rather than mere frequencies or incidence” (p.18).*

The focus of this PhD research from the outset was to investigate the *process* of service development within one Health Board area. In terms of understanding the key factors underpinning this process, questions of ‘how’ and ‘why’ were, therefore, particularly prominent. This research therefore lent itself to a case study approach. However, given that the term ‘case-study’ evokes different representation in the literature, it is first of all important to define the approach that I adopted.

#### **3.3.5. Case-study: a ‘method’ or ‘design feature’?**

One major criticism of the case study is that there is a lack of clarity over its definition. At the centre of this is the issue of whether it should be classed as a



‘method’, particularly when no data gathering techniques have been specified (Stoecker, 1991). Stoecker (1991) has defined the case study as “*a frame for determining the boundaries of information gathering*” (p.98). As a research design feature, therefore, the case-study facilitates the study of a phenomena in depth within a given context, and allows for the ‘boundaries’ of that context to be defined.

I considered the case study approach to be a useful *research design feature*, in that it provided me with a suitable logic for specifying the boundaries of my information gathering. A Health Board provided a natural geographical and organisational boundary, within which I could conduct an in-depth investigation of the issues associated with the development and implementation of the smoking cessation services. Furthermore, using a Health Board as a ‘case’ also provided another natural boundary for the study. This is, the coherent *policy system* that underpins the case: The Scottish Executive - Health Board - LHCCs - GP Practice level.

### **3.3.6. Choosing my ‘case’**

The original research proposal considered studying one specified Health Board region in Scotland. Upon conducting my preliminary fieldwork, it was clear that Health Boards varied in their adoption and implementation of the smoking cessation services. This variation appeared to be attributed to factors such as working history, size, geographical/population needs, and particular ways of working. I considered the possibility of comparing two different Health Boards. However, due to the in-depth nature of qualitative data, and the limited time resources available to the study, I decided to conduct an intensive study of one Health Board, rather than spreading data collection across two. For this reason I decided to use the specified Health Board region as a single case study.

While it was possible for me to study an alternative Health Board region to the one identified in the proposal, I decided against this for two reasons. Firstly, one key aspect of case study research is to maximise what can be learned, and therefore logistical considerations have been identified as justifiable grounds for case selection (Stake, 1995). In the case of my research there was no justifiable criteria for



choosing one specific Health Board region over another, as each Health Board represented a unique 'case' in its own right. Therefore, on logistical grounds, it made sense to remain with the Health Board originally identified. It was within easy travelling distance from the University, which I felt would facilitate the research process. Secondly, academics at the University were involved in a consultative role with the Health Board, in the early stages of smoking cessation service development within the Health Board. This therefore provided me with important contextual information, and details of key contacts, which may have been more difficult to establish elsewhere.

One further issue that I had to consider however was whether the notion of a 'case' should be extended to the LHCCs. The focus of my study (involving 7 LHCCs) and the different types of services developed within each LHCC, meant that my research inevitably took on a 'comparative' focus. If subscribing to the above definition of the case as simply determining the boundaries of information gathering, then the LHCCs could conceivably be regarded as cases in their own right (as independent 'units' within a broader policy structure). As the formal data gathering process progressed, and preliminary analysis got underway, the different experiences of LHCCs became more evident. It was clear at this stage that it would indeed be beneficial, both for analysis and discussion purposes, to consider each LHCC as smaller 'cases' in their own right. In essence, my research design became a comparison of 'mini-cases' within the larger single case.

### **3.3.7. What can be learned from my case study?**

As outlined by Stoecker (1991), a key criticism of the case study approach is its inability to allow for the generalisation of findings to other settings (Smith & Robbins, 1982; Berger, 1983). However, the literature would suggest that there is a clear role for case study research beyond simply understanding one particular case. Stake (1995) differentiates between the 'intrinsic' and the 'instrumental' case study. The 'intrinsic' case study represents the study of a case due to an *intrinsic* interest in that particular case, and are not studying it because of a desire to generalise beyond it, or build theories around it. However, the extent to which a researcher should use

their case study to understand other similar cases, or inform a wider knowledge-base, is a source of debate. Specifically, there is the view that research should not just consider the unique aspects of the case, but should also be concerned with having wider implications (Mason, 1996).

The term ‘instrumental case study’ (Stake, 1995) is used to describe research that uses the ‘case’ to understand a particular phenomenon. This can be done by seeking generalisable principles from the individual case that can be applied to other ‘similar’ cases. This resonates quite closely with the definition of the ‘explanatory case study’ in which “*researchers seek to make generalisations by extrapolating the single case study’s findings to other cases*” (Yin, 1994). Although the “first obligation” of the researcher is to understand the case, the case study can have a wider resonance by modifying, clarifying, and increasing confidence in “grand generalisations” (Stake, 1995, p.4-8). This dualistic view of the purpose of a case study has been echoed elsewhere:

*“The first [purpose] is what we can learn from the study of a particular case, in it’s own right...the case being studied may be unusual, unique, or not yet understood, so that building an in-depth understanding of the case is valuable...Second, only the in-depth case study can provide understanding of the important aspects of a new or persistently problematic research area...Discovering the important features, developing an understanding of them, and conceptualizing them for further study, is often best achieved through the case study”* (Punch, 2000, p.155-6).

Case study research can, therefore, be useful for drawing out the idiosyncrasies of a ‘case’, but also for expanding knowledge around a particular issue or given field of study. I felt that it was important for my research to consider both of these elements, and was based on an instrumental/explanatory case study design. Specifically, I was interested in generating knowledge around the development and implementation of smoking cessation services in primary care that would highlight the contextual idiosyncrasies of the particular Health Board under study. However, I was also keen to generate findings that would have wider resonance for health promotion practice and smoking cessation service development more generally.

### **3.4. Data Gathering**

#### **3.4.1. Documentary data**

I referred to official Health Board documentation such as primary care reports, documents produced around smoking cessation, and smoking cessation audit data. The aim of referring to these documents was to provide a context for the data that was generated via the interviews, and for checking factual information (e.g. dates; professionals involved in the Health Board's Tobacco White Paper Advisory Groups; numbers/types of health professionals trained). This documentation, however, was not used as 'data', in the way that 'methodological triangulation' (Stake, 1995) would attempt to assert the validity of research findings via two or more methods.

#### **3.4.2. Developing the Interview Guide**

Two topic guides were developed for this research. The first was for use with interviewees from LHCCs and the Health Board [Appendix One]. The second was for interviews with those members of the Health Board's Tobacco White Paper Advisory Group [Appendix Two]. I drew upon three sources of information in developing these interview guides. The first source was the conceptual framework underpinning my research- *service development, delivery, evaluation, and sustainability*. This conceptual framework provided not only an effective means of compartmentalising the topic guide into manageable 'chunks' for the interviews, but also provided a logical framework for ordering the questions.

The second source was the information generated from the informal discussions held in the early stages of the research, and key issues highlighted in the literature. Under each of the broad conceptual headings (development, delivery, evaluation, sustainability), I developed a set of sub-questions. These sub-questions were broadly generated from the data obtained from the preparatory fieldwork and literature reviews, which highlighted salient issues that would be usefully explored further in the interviews.

The third source informing my topic guide was the interview guide that had been used in the evaluation of the services in England, which I obtained from a senior academic leading this research. The focus of the research on smoking cessation services in England was more evaluation-focussed. However, many of the issues explored within the interview guide used for the research on English services, resonated with the issues I wished to investigate in my research. Additionally, the topic guide used for the service evaluation research in England, was also structured around the broader conceptual areas of development, delivery and sustainability. This was perhaps not surprising, given that the services had been set-up on a national basis, were underpinned by the same evidence-base/guidelines, and that in some aspects, my research was interested in looking at very similar issues. From this topic guide, I was able to identify if I had overlooked any potentially important issues for exploration. Following this, I refined my interview guide, by rewording questions and adding new questions accordingly.

### **3.4.3. Piloting the Interview Guide**

About ten months into the research, an opportunity arose for me to meet with a professional who held a key strategic role within one LHCC. This had come about through a meeting at an STCA (Scottish Tobacco Control Alliance) conference, whereby s/he had expressed an interest in my research. I was invited to contact him/her in order to discuss my research further, which I subsequently arranged. At this meeting, I took the opportunity to pilot my topic guide, and also test out my new recording equipment.

Unknown to myself, this professional had invited two other staff members from the LHCC to our meeting. As a result of the preparatory fieldwork I had carried out, I was aware that these two staff members were respondents that I wanted to involve in my research. I was expecting, however, to have interviewed them at a later, and more prepared, stage. However, given that these staff members had expressed an interest in my research, and had given up their time without my request, I was keen to treat this discussion as a formal interview. I felt that to request a further interview with

these staff members (at which similar issues would be discussed), would have placed an unnecessary burden on the respondents.

The professional who had originally invited me along was called away on a business matter about 20 minutes into the interview, and did not return. This form of interruption in the interview process has been found to be common when researching busy and professional people (Duke, 2002). However, the interview that was held with the remaining two staff members proved to be very fruitful. I found, however, that I used my topic guide less than expected, beyond the probing of broad issues around my conceptual framework. The interviewees generated much discussion around the topics in my interview guide, much more than I had expected. I was reluctant to interrupt the flow of discussion and thus intervened only when the focus of the interview had diverted from the key issues I wished to discuss.

At the end of the interview I asked questions around issues that I felt were not covered in enough depth, or needed explaining further. As this was my first interview, a few concepts were still unfamiliar to me. Given the success of the interview, I obtained verbal consent for using the interview data as part of my formal data-set. There was agreement that data extracts could be used. However, I was asked if I could make the data extracts available before submitting my thesis for cross-reference, as one interviewee had been mis-represented in a previous research study.

It has been suggested that a preference to be interviewed alongside colleagues within the same organisation can be underpinned by a concern for consensus (Duke, 2002). Ideally, it would have been preferable to interview each of the above interviewees separately. However, I was not overly concerned that a desire for 'consensus' was an issue in this case. The circumstances of the interview meant that the interviewees presented themselves for an informal discussion, as opposed to a formal interview. Additionally, the two respondents invited along to the discussion had a close working relationship. As opposed to a desire for consensus, therefore, the decision for both respondents to be included in the discussion was likely an intuitive one based on

their joint working history and partnership role in local smoking cessation service development.

The interview was transcribed immediately afterwards. Following my review of the topic guide, based on the data generated from this discussion, minor alterations were made. It was at this stage that I set about initiating the process of conducting my formal fieldwork (i.e. further recorded interviews using my interview guide). My decision not to conduct further pilot interviews was based on two factors. Firstly, in the informal fieldwork stage I had held discussions with a wide range of people in various professional roles. I had approached most of these discussions with my broad conceptual framework in mind, and I gained awareness of the key issues emerging around smoking cessation service development in Scotland, and within the Health Board under study. As these discussions had played a key role in informing my interview guide, I was confident that it would be an efficient research tool. The pilot interview re-affirmed this. Secondly, the informal discussions had provided me with invaluable experience of meeting with a range of professionals to discuss my topic area. I considered this to be a key part of the piloting process.

#### **3.4.4. Sample and Access**

I adopted a purposive sampling approach. This approach has been described as a method of selecting a sample that can best provide data on the key issues/processes that the research is focussed on:

*“Many qualitative researchers employ...purposive, and not random, sampling methods. They seek out groups, settings and individuals where...the processes being studied are most likely to occur” (Denzin & Lincoln, 1994, p.202).*

Purposive sampling is closely aligned with theoretical sampling, although the key difference is that *“the ‘purpose’ behind ‘purposive’ sampling is not theoretically defined”* (Silverman, 2000, p.105). Theoretical sampling involves the selection of a sample (prior to, or during, the research process), based on the researcher’s theoretical position, or theories emerging during the research process (Mason, 1996).



At the outset of the research, I wanted to interview respondents who could provide me with an insight into the process of service development within the Health Board/LHCCs. I was keen, therefore, to interview those key people who were involved in the development and delivery of these services, and could reflect on the issues of service evaluation and sustainability. Thus, my sampling strategy was a purposive one at this stage.

#### **3.4.5. Initiating the ‘contact’ process**

I sought advice from a senior academic colleague at the University, who had conducted extensive research with the Health Board, about how I might go about recruiting Health Board staff. I was advised in the first instance by this senior academic to contact the General Managers of each LHCC. This was an ethical approach to take as it (a) informed the General Managers of the research that I would be conducting, and (b) gave them the opportunity oppose my research, and to refuse me access to their staff on grounds that they might see fit (e.g. time required to conduct the interview). However, I also felt that I could use this initial contact with the General Managers as an opportunity to inquire about suitable interviewees.

I sent a letter to the General Managers of all the LHCCs [Appendix Three] in October 2002. In this letter, I provided details about myself, the research topic, the funders, the specific research questions, and what would be required of the interviewees (e.g. time involved). I also asked the General Managers if they could provide me with the contact details of potential suitable interviewees. I indicated to the General Managers that I would contact after a few days to answer any queries that they might have about the research.

This approach proved to be more fruitful than I anticipated. Within a week I had received positive *direct* responses from four of the LHCCs. I received a letter from one General Manager indicating that he would be happy for me to contact his staff, giving me contact details of two of the key people who were involved in service development and delivery within the LHCC. In three cases, I was contacted by the Development Managers/ Public Health Practitioner of the LHCC. In these cases, the



letter had been forwarded to them, by the General Managers, for action. This indicated to me that the General Managers approved of the research in principle, and of my intentions to interview their LHCC staff. In two of these cases I was invited to contact the Development Managers to arrange an interview. In the other LHCC I was informed by the Public Health Practitioner that he would send me a list of appropriate people to contact in due course.

The remaining four LHCCs were less forthcoming, and I subsequently contacted the General Managers. In one LHCC, I spoke with the General Manager, who then directly transferred me to the Development Manager for the LHCC. This Development Manager had already been informed of my research, and indicated a willingness to be interviewed. In another LHCC I was informed by the General Manager's secretary that two names (with contact details) had been left with her to give to me when I phoned. I felt that at this stage that this General Manager was less enthusiastic for staff to be involved in my research, given that he had been less forthcoming [this LHCC subsequently did not take part in my research]. This left two LHCCs unaccounted for. In one of these LHCC, I was informed by the General Manager that the letter had been passed to the appropriate person within the LHCC for action (I was given contact details), although I had not heard anything from this person. In respect of the final LHCC, I was informed by the General Manager of the key people to be interviewed within the LHCC. As it transpired, individuals identified were those interviewed for the 'pilot', which served to re-affirm to me their status as key stakeholders.

At the end of this initial contact stage, therefore, there was one LHCC in which the key stakeholders had been interviewed at the pilot stage. In five LHCCs, I was in a position to proceed with contacting interviewees and initiating interviews. Finally, I awaited further contact for interviewee details in two LHCCs. It was decided at this stage not to pursue these two LHCCs further. I was uncertain whether I would be involving all LHCCs in the research, and therefore decided to hold off making further contact until this had been decided. However, I decided to proceed with contacting these LHCC again in January 2003 (3 months after initial LHCC contact).

This was for two reasons. Firstly, it became clearer through the process of interviewing, that one of these LHCCs would provide an interesting case for understanding the development of local smoking cessation services. I was therefore keen to engage with this LHCC. Secondly, given that there had been no direct indication that these LHCCs did not want to participate in the research, I was keen to ascertain whether they wished to be involved.

I sent a letter to the key contacts of these two LHCCs, and received positive responses from both. The key contact of one LHCC indicated that s/he had tried to make contact following the initial letter that I had sent to the General Managers, but that this had been unsuccessful. It is uncertain whether this response reflected embarrassment at not initially responding to my letter, or whether genuine efforts had been made to contact me. However, there was enthusiasm to take part in my research, and I subsequently interviewed this person. With regard to the second LHCC, although I had been informed at the initial contact stage that the names and contact details of key people would be forwarded to me, this did not transpire. However, upon contacting this LHCC again, an interest in taking part in the research was confirmed, and the contact details of key respondents were subsequently provided.

Health Board staff who were responsible for the strategic/management of smoking cessation service development, were identified early on as being key to my research. In November 2002 I sent letters to two key contacts at the Health Board [Appendix Four]. Both agreed to be interviewed. In November/December 2002, I also sent letters to five members of the Advisory Group for the White Paper Programme [Appendix Four]. The criteria for selecting Advisory Group members was based on their ability to represent different organisations/views (e.g. General Practice; Academia; Health Board; National Strategy). Four members of the Advisory Group agreed to be interviewed, and one declined.

### 3.4.6. Initiating further interviews

After making initial contacts with the LHCCs, further key contacts were identified via a process of snowballing. As outlined by Mason (1996), initial contacts can provide researchers with a sampling frame, by recommending, or putting the researcher in touch with, other potential respondents. A 'snowballing' approach, is now a widely accepted method of respondent recruitment (particularly where specialist knowledge is required). At the end of each interview, I asked interviewees, where appropriate, if they could recommend anyone else for interview. This process has been shown to be effective as a method of establishing an "*accurate picture of the membership and shape of the policy network*", and the "*major players*" in this policy network (Duke, 2002, p.47). I felt that this was a legitimate method of respondent recruitment. My initial contacts and interviews were held with people who played a key role in the early development of the services, and who continued to have strategic management over the services in some way. Therefore, I felt that their judgement about suitable interviewees was reliable given their insight into the services within their area.

However, I did consider whether some names may have been suggested to me for other purposes, including the knowledge that this particular person might portray the LHCC services in a positive light. Research on policy networks has indicated that there can be an "official line" (Duke, 2002, p.46), and also that there can be a desire for consensus amongst research participants (Fitz & Haplin, 1994). Therefore, I considered that names may have been suggested to me because they represented/reinforced official LHCC 'policy' or experience of local smoking cessation service development, and/or shared similar viewpoints to those of the initial contacts. Through the process of conducting more interviews, and reflecting upon the data, a picture began to emerge of who the 'key players' were within each area. With regard to one LHCC I was aware that one the key people involved in local service development had not been identified as a 'key contact' for interview. A key stakeholder in another LHCC was on maternity leave at the time of conducting the interviews, which meant that she could not be involved in the research. However, besides these three cases, the 'key names/contacts' emerging from the interviews

reassuringly reflected the advice I had been given from initial contacts about who the key contacts/stakeholders were within each LHCC.

Table 1, below, outlines the professional roles of the 34 interviewees who took part in this research. The pilot interview, which involved 3 interviewees, was conducted in August 2002. The remaining 31 interviews were conducted between November 2002 and April 2003.

**Table 1: Interviewees by Professional Role**

<p><i>Management (Health Board and LHCC)</i></p> <p>Health Board staff (3)  Development Manager (3)  Public Health Practitioner (2)  Clinical Director (1)  Health Promotion Specialist (1)</p>	<p><i>Nursing/GP practice staff</i></p> <p>General Practitioner (2)  Health Visitor (5)  District Nurse (2)  Practice Nurse (3)  Smoking Cessation Nurse (2)  Nurse (1)  Primary Care Nurse (1)</p>
<p><i>Pharmacy</i></p> <p>Pharmacists (3)  Primary Care pharmacy/prescribing Advisor (2)</p>	<p><i>Advisory Group Members</i></p> <p>ASH Scotland representative (1)  University Academic (1)  Tobacco and Drug Issues worker (1)</p>

### 3.4.7. Approaching interviewees

Upon receiving contact details for potential interviewees, I sent them each a letter [Appendix Five]. The letter explained how I had received their details, provided information about myself, the study (aims and objectives, funders, what would be

required from interviewees), my contact details, and indicated that I would contact them in due course to find out if they would like to be interviewed. I also stipulated where I had received their contact details, and who had recommended them. The main reason for this was that I did not wish to appear that I was 'cold-calling', which I felt might generate a negative response. I also enclosed an information sheet [Appendix Six], which outlined the purpose of my research, and the research questions, in more detail.

Three interviewees emailed/phoned expressing an interest in being interviewed, and I subsequently arranged an interview date. I phoned other potential interviewees directly and arranged an interview date. Interview dates ranged from two weeks to six weeks from the point of contact with the interviewee, although four weeks was the norm.

The response from those I contacted was generally very positive. There were eight LHCCs within the Health Board. To reiterate, one LHCC was not included in the research, as the two key people identified did not wish to take part, and no other key contacts had been recommended to me regarding this LHCC. Three other people also declined interview (including one Advisory Group member). However, this did not impact upon the inclusion/exclusion of any other given LHCC, as other LHCC staff members were involved in the research.

I did not expect the level of positive feedback that I received from my letters to potential interviewees. Interviewees were busy, working professionals, most of whom had other priorities in their workload beyond smoking cessation. As a PhD student, and therefore a lone researcher with relatively low status (Duke, 2002), I expected there to be a lesser degree of willingness from such professionals to engage in my research. However, given that I was associated with a respected academic institution, and that I was funded by The Scottish Executive, this may have elevated my 'status' as a researcher. Hunter (1995) has proposed that a researcher's academic status, the organisation funding the research, and the researcher's institution, can balance the power relationship between researchers and 'elite' respondents.

It is possible that given interviewees, in many cases, were aware that someone else (often higher on the professional hierarchy) had recommended them, they felt obliged to be interviewed [this issue is discussed in more depth in section 3.6 on ethical considerations]. However, the demeanour of interviewees was generally welcoming at the interviews, and a high degree of interest was expressed about my research.

### **3.5. The Interviews**

#### **3.5.1. Format of the interviews**

The interviews took place in the interviewees' places of work, with the exception of three, which were conducted within the University. When interviews were conducted outwith interviewees' place of work, this was a preference stated by the interviewee (either it was close to their home, or they worked from various locations and had no office base). It has been suggested that the location of an interview can influence the interview process (Richards & Emslie, 2000). It is possible, therefore, that interviewing within 'my' place of work as opposed to the interviewee's, might have impacted upon the type of data generated in the interview. However, the interviews that took place within the University, did not noticeably differ, in terms of content or tone, from those that took place in interviewees' place of work.

Prior to the interview commencing, I re-iterated the aim of my research, what the interview would involve, and the key research questions underpinning my research. I outlined the research questions at this point in order to provide a focus for the respondent and the interview. Interviewees were then given a consent form to sign [Appendix Seven], and I ascertained their willingness for me to record the interview. All interviewees were happy to proceed with the interview, although one interviewee expressed concern about anonymity [this issue is discussed in more depth in section 3.6]. Interview length ranged from approximately thirty minutes to one-and-a-half hours. Most interviews fell within the forty-five minute to one-hour bracket. All interviews were recorded, and the sound quality was generally very good. However

the quality of one recording was poor due to environmental noise, and therefore this interview could not be transcribed fully.

Out of the 32 interviews (including the pilot interview), 25 were transcribed verbatim by myself. Due to time pressures, and the preference for a close temporal relationship between interview and transcription, a further seven interviews were transcribed verbatim by an experienced transcriber. These transcriptions were checked thoroughly for accuracy against the interview recordings.

As in the pilot interview, I was surprised by how little I had to direct the interviews. In many of my interviews, the interviewees responded to my questions in a very detailed manner, and therefore it was not necessary for me to constantly probe them for discussion around my sub-questions. This was particularly the case when I interviewed those in a more strategic role. The reason for this may be that these respondents had a broader insight into many of the overarching issues. For the most part, the interviews were more conversational and spontaneous than a typical question-answer/probe-style interview. I was aware, however, that when interviewees did talk at length around issues that I should maintain control of the interview. However, it was not often necessary for me to interrupt and/or probe, because I deemed much of the discussion relevant to the research. Only where I felt that the discussion was going off in a tangent, did I re-direct the interview using the interview guide.

In the interviews conducted with staff in a service delivery role, more probing was necessary. This may be attributed to the fact that these interviewees held positions that did not require them to consider the issues that I was exploring in their 'broadest' sense (e.g. funding; national strategy). They may, therefore, have been specifically focussed on service delivery issues. However, that in itself was an important issue for the research, as I was keen to explore the experiences and reflections of smoking cessation service implementation from a range of perspectives.



### **3.5.2. Interplay between Data Analysis and Data Collection**

Following each interview I made detailed notes on the event. These notes included information about any ethical concerns I had, general demeanor of the interviewee and whether I thought they were guarded/open. These notes were taken to help me locate the interview within a broader contextual framework at the data analysis stage. Transcription began as soon as possible after each interview.

As outlined previously, the emergence and investigation of emic issues is a crucial component of interaction between the researcher and those being researched, which is integral to the constructivist paradigm (Guba & Lincoln, 1998). Following an interview with a respondent in a strategic role, two issues were raised by this respondent that I had not previously identified as key issues. These issues related to (a) smoking cessation as a 'core' work activity, and (b) the place of smoking on the national political agenda. I subsequently incorporated these issues within my interview guide. Additionally, prior to interviewing LHCC staff members, I listened to/read the recordings/transcripts of other interviews from staff within the same LHCC. This allowed me to identify key issues that were pertinent to that particular LHCC. The aim of this exercise was to discuss these issues with other LHCC staff members who were perhaps coming from a different perspective (e.g. strategic versus delivery).

Early analysis of the data led me to reconsider my sampling decisions. I felt that involving other key respondents (e.g. pharmacy) and LHCCs in my research would supplement the data that I had collected up until that point, and add new dimension to some key issues that were emerging from the research. I therefore adopted a theoretical sampling strategy. Theoretical sampling has been described as a key component of the interactive process between data analysis, emerging theories, and sampling decisions (Mason, 1996):

*“Theoretical sampling means selecting groups or categories to study on the basis of their relevance to your research questions, your theoretical position and analytical framework, your analytical practice, and most importantly the explanation or account which you are developing. Theoretical sampling is concerned with*

*constructing a sample (sometimes called a study groups) which is meaningful theoretically, because it builds certain characteristics or criteria which help to develop and test your theory and explanation” (p.93-94).*

Theoretical sampling is a key component of the Grounded Theory approach<sup>1</sup> whereby sampling decisions are grounded in theories emerging from the data (Chamberlain, 1998). That is, with regard to two LHCCs, I decided to interview more respondents because I felt it would supplement the existing data and provide me with a more balanced view of the situation within that particular LHCC. This interaction with the data led me to consider sampling new populations (i.e. other LHCCs). As outlined previously (section 4), after the initial contact stage I decided to refrain from contacting two LHCCs that had not provided me with direct responses. However, as the fieldwork progressed, it became clear that service development within some LHCCs had occurred at a different rate than others. Based on interviews conducted up until this point, it was clear that one of the LHCCs, not included in the research, represented a ‘unique’ case in terms of its protracted rate of local service development. I was keen for the data to represent as wide a range of experiences as possible. I therefore felt at this stage that it would be beneficial to contact those LHCCs to establish whether they wished to participate in the research. As outlined previously, these LHCCs subsequently became involved in my research.

At this stage of the research process, I also re-evaluated the original research proposal, which stipulated that two rounds of interviews would be conducted. The second round of interviews was intended to address the question/issue of service sustainability. This second round would have been conducted approximately six months after the initial round of interviews, whereby it was expected that issues pertaining to service funding/sustainability would feature more prominently in discussions held with interviewees (given that ring-fenced funding ceased in 2002). It became increasingly clearer as the fieldwork progressed, however, that this second round would not be necessary. The issue of service sustainability was one that was highly pertinent to discussions held with interviewees in the first round of interviews,

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<sup>1</sup> Data Analysis in PhD took direction from a Grounded Theory Approach (Glaser & Strauss, 1967)

and I did not, therefore, deem it necessary to conduct a second round of interviews to explore this issue.

### **3.5.3. How was my research perceived (and how may this have impacted upon the data)?**

Throughout the data collection phase I was aware of how my research might be perceived by interviewees, and how this might impact upon the data. In particular, I was aware that interviewees knew that the research was funded by The Chief Scientist's Office/The Scottish Executive. This led me to consider how this might have affected interviewees' responses. On a few occasions, for instance, I felt that some interviewees (particularly those in a strategic role), had their own agenda for the interview. On a couple of occasions interviewees inquired about how my research would be utilised by The Chief Scientist's Office/The Scottish Executive. I responded by clarifying that the funding allocated to the studentship reflected an interest in the topic area by The Scottish Executive, although I was unsure about how my research would be utilised in a formal capacity.

My research may, therefore, have been regarded as a mouthpiece for expressing certain views around the perceived lack of funding, or inefficient monitoring of smoking cessation services. It is possible that some interviewees may have expected my PhD research to feed directly into the policy cycle, and therefore believed that they may be able to influence policy in this way. For interviewees, therefore, who wished smoking cessation to remain high profile, or those who would have preferred it to have less political profile, the interview may have been viewed as an opportunity to 'promote their cause'. For instance, I felt that one interviewee (who held a strategic role in one LHCC), despite attributing her decision to be interviewed to 'altruistic' motives, had certain views that s/he clearly wished to express.

I also considered the possibility that some interviewees may have wished to portray themselves, and/or their services in a positive light. However, while this thesis cannot comment on the 'truthfulness' of respondent accounts, it appeared to me that interviewees were fairly candid in expressing their perceptions of smoking cessation

services. This is supported by the high degree of consistency in accounts both within, and between, LHCCs, and in interviewees' accounts more generally.

### **3.6. Ethical Considerations**

At the time the research proposal was drawn up for funding and approval by the Chief Scientist's Office (CSO), ethical approval was not required for the research. However, prior to commencing the fieldwork, I sought advice from a senior academic at the University who had carried out extensive research with the Health Board under study and who was therefore in a position to advise me on the ethical procedures for researching NHS staff. S/he recommended that I contact the General Managers of each LHCC, in order to gain consent for interviewing their LHCC staff. This was an ethical approach as it allowed General Managers the opportunity to refuse my research, and therefore deny me access to their LHCC staff. I subsequently contacted all General Managers via the process outlined in section 3.4.5. While this was the best course of action for me to take at that time, it should be noted that since my fieldwork was carried out the ethical guidelines for research involving NHS staff have changed.

At the time my fieldwork was being conducted, Community Health Sciences (CHS) at the University of Edinburgh was in the process of drawing up a Research Ethics Code of Practice for postgraduate students. However, it had yet to be implemented in practice. Under this Code of Practice, postgraduate students are now required to seek LREC (Local Research Ethics Committee) approval for research involving NHS staff.

My research conformed to the ethical guidelines that informed The Code of Practice being developed at that time by CHS. Hence it observed the practices outlined by the British Sociological Association's Statement of Ethical Practice, and the Code of Practice and Ethics Review Checklists developed by Oxford Brookes University. Specifically, I observed key ethical requirements of data protection, confidentiality, informed consent (including the provision of an information sheet about my research to participants in advance), and maintaining the voluntary nature of research

participation. Additionally, key research findings will be disseminated to those who participated in my research. Two ethical issues, however, were particularly pertinent to this research. These issues, which involve consent and anonymity, are discussed in detail in the following sections.

### **3.6.1. Consent**

Consent for the interviews was obtained immediately prior to the interviews taking place. Hence participants were asked to read and sign a consent form [Appendix Seven]. The consent form conformed to ethical guidelines, outlining the title and purpose of the study; why the respondent was selected; an outline of what the interview would involve; the voluntary nature of research participation and the right to withdraw at any given time; actions that would be taken to maintain confidentiality and anonymity; and my contact details. A copy of the consent form was retained by myself and the interviewee. To ensure that this consent *informed*, it outlined the broad aims and objectives of the research, and the sampling strategy that the research involved. Additionally, I had included an information sheet [Appendix Six] along with the letter inviting the respondent to be involved in my research. All interviewees readily signed the consent form prior to interview, although one interviewee expressed concern about anonymity.

It has been proposed that researchers should be cautious about how readily consent is accepted (Mason, 1996). Specifically, it is important to consider the pressures and influences that may affect motivation to offer consent. This resonated quite strongly with me. I suspect that a common motivation for agreeing to participate in my research, beyond altruistic motivations, included a genuine interest in smoking cessation issues and a belief in the importance of my research. Many of the people interviewed were enthusiastic about smoking cessation and indicated that they would be interested to learn about my research findings. However, I was aware that given the research was funded by The Chief Scientist's Office, it may have been perceived by some interviewees as a potential 'mouthpiece'. However, there were two occasions whereby I was uncomfortable with motivations underpinning consent.

In the first case, it was clear at the interview stage that the respondent was not entirely comfortable. This interviewee held a strategic position at work, and they expressed concerns around anonymity. It is possible this particular interviewee felt 'obliged' to take part in the research given their work role generally and their role on smoking cessation services particularly. Concerns around working relationships and power structures, meant that this interviewee was less comfortable about discussing certain interview topics.

In the second case I pursued a particular LHCC that had been less forthcoming than others. At an early stage of the research I received positive feedback from a key contact / within this LHCC who informed that I would be sent names of key contacts. To reiterate, this information was not received and thus I had to renew contact in order to establish whether the LHCC was still interested in being involved in the research. I was reassured of willingness to participate in the research, and told that the original letter [with details of key contacts] had 'got lost'. Despite this reassurance, the LHCC may not have been particularly enthusiastic about the research for the following reason. The rate and form of local smoking cessation service development within this LHCC was more protracted compared to other LHCCs. Consequently, it is possible that respondents within this LHCC may have felt 'obliged' to participate given that other LHCCs were involved.

Another concern that these interviewees may have had was that of anonymity. It is quite possible because of the differences between LHCCs and the power/employment structure of the Health Board/LHCCs, respondents saw themselves as easily identifiable. Although I emphasised the voluntary aspect of participation, it is possible that this interviewee/LHCC felt somewhat 'obliged' to take part in the research. I was aware, therefore, that the challenge and responsibility would lie in dealing with this interview data in a delicate manner, taking into consideration the underlying concerns these interviewees may have had with my research and its implications. This leads onto the issue of anonymity.



### **3.6.2. Anonymity**

The consent forms stipulated that data extracts used in the thesis would not be linked to the names of interviewees, or LHCCs. However, it became clear when writing the data chapters, that despite not using names of interviewees or LHCCs, it was extremely difficult to eliminate all identifying ‘features’ from the data. LHCCs differed in terms of structure (particularly one LHCC), the types of services that were developed, and the key people/professional roles involved in the development and delivery of local services. Despite attempts to anonymise the data extracts, it was clear that those familiar with the Health Board/LHCCs, and the services developed locally, might be able to identify the LHCC, and/or the respondent. I was also aware that the issue of anonymity might be more pronounced given that respondents within some LHCCs were aware of other LHCC staff who were interviewed. Key respondents had often been recommended to me, and I was aware that discussions within local policy networks might reveal who had been interviewed as part of the research. Indeed, Duke (2002) has raised the important question as to whether research participants should *also* be responsible for maintaining the anonymity and confidentiality of other participants.

Three key measures were taken to minimise identification of LHCCs/respondents, and to uphold the integrity of those interviewed. These three measures included (a) not including certain data extracts, (b) using generic job titles where appropriate, and (c) requesting additional permission from one LHCC to include data extracts.

#### **3.6.2.1. Exclusion of Data Extracts**

Given the professional role of those interviewed within this research, combined with the potential of respondent identification, there were certain data extracts that I did not deem it appropriate to include. Firstly, where respondents expressed negative views about an individual, data extracts were not used. This was not only because the person may have been identifiable, but also because I did not believe exclusion of the data extracts would skew the representativeness of the data. Secondly, some Health Board respondents were very candid about the processes involved in developing smoking cessation services. However, I was uncomfortable about



reflecting upon these processes in detail in the data chapters. Again, this was due to the possibility of certain people being identifiable, and given that the data extracts discussed matters concerning internal/professional conflict, I did not feel that it was appropriate to include them.

### **3.6.2.2. Use of generic job titles**

In the initial drafts of the data chapters, IDs provided at the end of data extracts related to the respondent's professional role (e.g. Development Manager; Public Health Practitioner; Smoking cessation co-ordinator; GP). However, it became clear that use of IDs in this way was problematic. Where identification of the LHCC was possible (e.g. the data extract revealed a type of service delivery unique to one LHCC), this allowed for identification of particular respondents. To minimise the potential of respondents being identified by their job title, respondent IDs were re-labeled according to generic job titles. The following format was applied:

- Interviewees involved in delivering smoking cessation services were labeled '***Service Delivery***', as opposed to 'health visitor', 'practice nurse', 'pharmacist'.
- Interviewees involved in a management/strategic role within the LHCCs (i.e. Development Managers; Public Health Practitioners; Clinical Directors), and those who undertook the role of local smoking cessation co-ordinator were re-labeled '***LHCC Management/Strategy/Co-ordination***'. I considered having a separate category for local service co-ordinators. However, this would have allowed for the identification of respondents. Additionally, some local service co-ordinators were Development Managers and/or Public Health Practitioners. I therefore considered it best to represent these respondents under one category.
- Three Health Board employees were interviewed. These respondents were simply labeled '***Health Board***', with care taken not to use data extracts that revealed one particular respondent.
- Those interviewees who were part of the Advisory Group for the Health Board's Tobacco White Paper Advisory Group were labeled '***Advisory Group***'.

### **3.6.2.3. Gaining additional permission to use data extracts**

One of the LHCCs involved in the research represented a unique case, in terms of both the strategic structure of the LHCC, and the type of smoking cessation service developed locally. At the interview stage, respondents from this LHCC indicated that they wished to view the data extracts that I would be presenting in my research report, as one respondent had been misrepresented in previous research. I asked that in considering the inclusion/exclusion of data extracts, respondents be aware of the difficulty in maintaining anonymity given that (a) the unique nature of the LHCC and its service was easily recognisable, and (b) the interviewees were widely known as being 'key' people in smoking cessation service development. Upon reading the data extracts, respondents indicated that they were happy for me to use the data extracts, and surrounding text, in my Thesis. One respondent, however, indicated that I had used the term 'Grade 3 nurse' as opposed to 'Grade G nurse'. This respondent also indicated that a sum of money referred to in one of the data extracts was accurate (as far as s/he was aware) at the time of the interview, but had since changed.

## **3.7. Data Analysis**

### **3.7.1. Data familiarisation**

Data analysis at the fieldwork stage has been described as inevitable, given that researchers are exposed to the data at this stage, and are able to reflect upon it (Pope *et al.*, 2000). To reiterate, the data collection stage informed the sampling strategies that I adopted in my fieldwork. Early 'analysis'/thoughts about the data were, therefore, generated at the fieldwork stage, which was an important part of the data analysis process.

Data transcription was carried out as soon as possible following interviews. Following transcription, the transcripts were formatted for input into the qualitative software package NUD\*IST. The process of transcribing was a crucial one for familiarising myself with the transcripts and for forming initial thoughts about the data. For instance, from an early stage, I identified several key issues that repeatedly emerged from the transcripts. I noted these for future reference at the in-depth data analysis stage. Furthermore, reading and re-reading of the transcripts was important

in generating an interplay between data analysis and data gathering. As I outlined previously, data emerging from the transcripts acted to inform my topic guide, as well as my sampling decisions around interviewee/LHCC selection.

The importance of personally transcribing the interviews became more evident to me after several had been transcribed by one other person (seven out of the thirty-two). The decision not to transcribe some interviews personally was a function of time. That is, because several interviews were carried out within a very short space of time, there was a transcribing backlog. As I was keen to maintain a close temporal relationship between conducting the interviews and transcription, having interviews transcribed by another appeared to be a sensible use of resources. Although the benefits of this were obvious in terms of keeping on top of the data gathering process, it also highlighted the crucial role that transcribing played in generating insightful thoughts about the data. I personally checked transcripts for accuracy with the tape recordings, although, initially I felt less close to the data from those interviews which I did not transcribe myself. It took several readings of the transcripts to provide me with the level of familiarisation that I had with the data I transcribed personally. For this reason, the process of generating themes from these transcripts was protracted.

Data analysis for me began, for the most part, at the transcribing stage. By the time all the interviews were transcribed, I had formed initial ideas about the data, and extracted issues that appeared to be prominent at that early stage of analysis. The next stage involved immersing myself in the data at a deeper level.

### **3.7.2. Data immersion & early analysis**

This stage of data analysis involved collating all my transcripts, and reading them through several times in order to develop a greater level of awareness of the data. I organised the transcripts according to LHCCs as this made it easier for me to obtain a general picture of each LHCC 'story'. I systematically went through each transcript and noted next to the text any key points that I felt were emerging from the data. At this early stage of the analysis, this primarily consisted of 'process' data (i.e. relating

to the stages the LHCCs went through in developing and implementing the services). It also included key issues that I felt stood out in the data (e.g. funding concerns; key/motivated people; evaluation; meetings target group needs etc).

My approach to data analysis took direction from a grounded theory approach (Glaser & Strauss, 1967), whereby the development of key categories and sub-categories representing the data, were generated inductively. A 'pure' grounded theory approach places a heavy emphasis on the *inductive* process of analysis although it has been recognised that conceptions of this approach can often place too much emphasis on the 'pure' form of inductive analysis, failing to consider a more realistic application of the approach (Strauss & Corbin, 1998). Specifically it has been proposed that researchers can be 'theoretically sensitized', bringing their own knowledge, reading, and approach to the data analysis process. (Strauss & Corbin, 1998). Similarly, Barbour (2002) has advised against the "*uncritical adoption of grounded theory*" (p.1116) that does not adequately account for how the data was generated and theories emerged (e.g. literature reviews conducted prior to the data collection/analysis stage, and pre-determined thoughts about data that you might be likely to collect).

With regard to my research, although I approached the analysis process in an inductive fashion, it was partly guided by the conceptual framework underpinning my research. The four broad conceptual strands of *development*, *delivery*, *evaluation*, and *sustainability*, informed my research questions and topic guide. It therefore made sense to me to approach the task of data analysis with these concepts in mind. Indeed, it has been proposed that using one's theoretical or conceptual framework is a legitimate precedent for coding in the initial stages of the data analysis process (Coffey & Atkinson, 1996). Therefore, upon analysing the transcripts, I maintained an awareness of how the data might relate to my conceptual framework, but at the same time made a conscious effort to extract meaningful data inductively.

Following this stage of data analysis, I had extracted a substantial amount of 'process data', and had developed an awareness of some of the 'key issues' in my transcripts.

At this stage I was considering the possibility of these issues becoming potential 'themes'. My analysis was therefore primarily descriptive at this stage, and I identified my next step as moving onto developing more meaningful themes with which to interpret the data.

### **3.7.3. Progression from 'process data' to meaningful analysis**

A key step in moving my analysis forward at this stage was to move beyond focussing on the 'process' data, and to consider generating more meaningful ways of analysing the transcripts. A useful way of doing this was to draw-up what I termed my 'LHCC Profiles', which consisted of short stories for each LHCC. These profiles outlined the key stages of the development and implementation of the services within each LHCC. This then allowed me to move beyond considering the 'process' in its simplest form (i.e. descriptive recounting), and to couch this data in a broader thematic and contextual framework (Strauss & Corbin, 1998)

I proceeded to work through the transcripts systematically once again. However, I increased efforts to look for broader, more meaningful issues in the data. I focussed less on the mechanical processes of service development and implementation, and I started to code the data through the development of broader themes. The constant comparative method is a key component of coding/category generation, which involves the constant comparison of themes/categories developed for similarities, differences, and negative instances (Pope *et al.*, 2000; Chamberlain, 1998). I developed as large a number of broad themes as was required to reflect the issues in the data. I consistently reflected upon the applicability of these themes throughout the analysis of each transcript, and modified themes according to new instances in the data.

Many the themes remained unchanged from the 'key issues' I identified at an earlier stage. I also identified new themes upon looking at the data in this more insightful way. I also maintained an awareness of the conceptual underpinnings of my research throughout this coding process. I continued to record how I considered the themes to interact with my four conceptual strands (development, delivery, evaluation, and

sustainability). At this stage, however, it was clear that there was another potentially useful conceptual strand, which was *Funding*. The issue of funding underpinned much discussion around the development, delivery, and sustainability of services. Therefore, it felt appropriate to consider this as a separate conceptual strand at this stage.

The size of text segments that were coded varied. However, I preferred to code larger segments in order to provide details of the context preceding and following the data extracts. Due to the nature of my interviews, the transcripts tended to consist of large sections of text without breaks. Interviewees often talked at length about various issues in response to my questions, and often went on to discuss other issues without probing. For this reason, it was not suitable to code a text segments with my question as a starting point. Instead, I coded larger segments in order to place the data within its context.

This process led to a more insightful interpretation of the data through the development of broad themes that represented important issues emanating from the transcripts. However, further interpretation and organisation of the data was still required, as the coding up until this stage essentially represented a “data-reduction” process (Coffey & Atkinson, 1996, p.35). Essentially my coding had compartmentalised the transcripts according to themes, but I recognised that these themes were still fairly broad in themselves. Conceptual organisation was required in order to represent the data more eloquently. This conceptual organisation involved two key stages, which are outlined in the following section.

#### **3.7.4. Conceptual organisation**

##### ***Stage 1***

I attempted to organise the themes that I had developed inductively within a conceptual framework. The most natural framework for me to choose was the one that underpinned my research- the four conceptual strands of *development*, *delivery*, *evaluation*, and *sustainability*. Although I had been considering this framework in a



flexible way throughout the data analysis process, I wanted to consider how it would represent my data more formally. I therefore began to code the transcripts once again, although this time into 'categories' and 'sub-categories/themes'. The sub-category referred to the themes that I had developed, such as "dedicated staff", and the category related to the conceptual strand that I felt represented the context within which the theme-coded text was placed (e.g. sustainability). For instance, if an interviewee talked about the importance of dedicated staff in ensuring service sustainability, I would mark the transcript as '*Delivery - Dedicated staff*'. Some sub-categories were also broken down further into what I termed 'cells'. For instance the sub-category/theme 'Targeting' had several key 'cells', including *funding*, *demand*, *appropriateness of the primary care setting*. I felt that by delineating sub-categories into cells, where appropriate, this would facilitate data organisation at the write-up stage.

Upon coding many of the transcripts using this approach, it became clear that there was a significant overlap, and several sub-categories/themes appeared under different categories. It was at this stage that the next step in conceptual development occurred.

## ***Stage 2***

I listed all my sub-categories/themes under their existing categories. At this stage, the categories became less prominent, and I began to look for conceptual and thematic links between my sub-categories/themes. The aim of this exercise was to organise my sub-categories/themes in a more meaningful way. I was keen to move beyond the broad categories of *development*, *delivery*, *evaluation*, *sustainability* and *funding*. It was becoming clearer by this stage that these categories were no longer conceptually meaningful as a way of interpreting and presenting the data. Instead, I was aware that discussion around these issues (particularly service *development*, *delivery* and *sustainability*), would evolve in the process of discussing the sub-categories/themes, and did not therefore require explicit categorisation.



In order to establish conceptual links between my sub-categories/themes, I assessed the sub-categories/themes for similar underlying concepts. For example, I linked the sub-categories/themes of *Training*, *Funding*, and *Evaluation* to the wider issue of 'Strategy', given that they were structural/political issues. The sub-categories/themes of, for example, *LHCC demographics* and *existing structure/ways of working*, were linked to the wider issue of *LHCC Capacity*, given that these sub-categories/themes related to LHCCs' capacity to develop smoking cessation services. Upon completing this process, I ended up with four conceptual categories (Commitment; Interventions; Strategy Interpretation; Service Development and LHCC Capacity), which formed the basis of my four data chapters. The final coding framework is displayed in Appendix eight.

As is displayed in Appendix eight, there were still some over-lapping sub-categories and cells (core vs additional; appropriateness of primary care; priority-agenda-investment), as I felt that some themes spanned two conceptual categories. However, in most cases the *same* data was not coded twice and included under two conceptual categories. Instead, different aspects of one theme were coded separately. I will use the sub-category/theme of *priority-agenda-investment* as an example here. Where interviewees discussed prioritisation or agenda-setting around smoking cessation at the Health Board/Scottish Executive level, I coded this under 'Strategy Interpretation'. However, where interviewees discussed this issue in relation to *LHCC* agenda-setting, I coded it under 'Service Development and LHCC Capacity'.

The interview transcripts were then re-coded using this new coding framework (Appendix Eight). Once all the transcripts were coded, I transferred all of my data transcripts onto the qualitative software package NUD\*IST. I then used this package to record my transcript codings. I did not use NUD\*IST for any other purpose other than to store and retrieve the data coded under each category/sub-category. It was at this stage that I started to write my data chapters.

### 3.7.5. Writing the data chapters

Writing the data chapters played an important role in refining the data analysis process. The four conceptual categories proved to be workable and representative way of organising the data chapters, and I was happy to use this framework throughout. Broadly speaking, the sub-categories/themes defined under the conceptual categories in Appendix eight remained the same. However, through the process of writing about the data that it was possible to refine, amalgamate, or discard certain sub-categories/themes and/or cells. For instance, where certain sub-categories appeared under two different conceptual categories, the writing process highlighted the sometimes ‘artificial’ nature of coding them under two categories. For example, the issue of ‘core versus additional work’ was originally coded under the conceptual categories of ‘Commitment’ and ‘Strategy Interpretation’. However, it later became clear that it made more sense to discuss these issues together, rather than separately in two data chapters. In such cases, I amalgamated both sets of data.

The process of writing about the data also aided conceptual refinement. I therefore considered the write-up stage to form an important part of refining my data analysis. There was a constant inter-play between writing, appraisal of the conceptual categories, sub-categories/themes and cells, and the desire to present a coherent account of the data. Some smaller sub-categories rendered themselves less significant in the write-up stage, and were subsequently not discussed in depth. In a couple of instances, certain sub-categories/themes within and/or between conceptual categories were amalgamated to create one sub-category/theme. For instance, the following sub-categories/themes were amalgamated into the broader sub-category/theme of ‘Motivational Approach’, under the Category ‘Interventions’ [Appendix eight]:

- *Stages of Change & Motivational Approach* (discussions focussing on interventions/service delivery based on the Stages of Change approach and/or patient motivation).
- *Maintenance Strategy* (discussions around offering interventions post 6-weeks to maintain motivation).
- *Availability-access-flexibility* (discussions around making services flexible and accessible at a time when patients are motivated to stop).

An example of the coding process, from initial conceptual organisation and early analysis to the deeper level of conceptual development, is demonstrated with the following data extract:

*“I think the last figures we got, it was something like...46% or something...success- at a year. Now that it quite high, because they reckon that the highest you could possibly get would be between 20 and 30%. But I mean we’re not the highest Locality at all, I mean a lot of the Localities....But I think it’s because we’re not just taking any old Joe Bloggs in, and trying to get them to stop smoking. We’re only taking on those that are just so motivated- because they’d [one word?] on the list, they come out to the information evening, they’ve had to return forms to us- they are really motivated. When they come, they stay, and they’re determined to stop”.*

This data extract provides a working example of the coding process that I undertook in the analysis of my transcripts. In the initial stages of data analysis, this data extract was identified as relating predominantly to the conceptual category ‘Delivery’, as it discussed the way in which the local service was structured and delivered. I also coded it according to the conceptual category ‘Evaluation’, at this early stage, as it discussed the success rate of the local service. At an early stage, ‘stages of change approach’ was identified as a potential sub-category/theme, as the data extract discussed the issue of patient motivation. However, at the more complex stage of conceptual development and refinement of sub-categories/themes, it became clear that this data extract was concerned with the issue of providing a service/intervention that was underpinned by a motivational approach. In particular, I interpreted it as discussing the delivery of a high threshold service (whereby patients are motivationally screened). Consequently, this data extract came to be coded under the sub-category/theme of ‘stages of change/motivational approach, within the broader category of ‘Interventions’. As outlined above, the sub-category/theme was amalgamated into the broader sub-category/theme of ‘*motivational approach*’.

### 3.7.6. Framework for data reflection

I did not conduct this research with a pre-determined theoretical and/or organisational framework in mind. Data collection and data analysis was approached inductively, with only the broad conceptual framework underpinning my research (*service development, delivery, evaluation, and sustainability*) guiding the research process.

However, when moving onto the discussion and interpretation of my research findings, I drew upon one framework that I felt was particularly useful for organising and reflecting upon my research findings. As outlined in chapter two, Wolfe (1994) proposed that in considering the diffusion/implementation of a given innovation/strategy within an organisation, it was important to define two key factors. Firstly, Wolfe proposed that the characteristics of the *innovation* (strategy) should be defined. Secondly, he argued that it was crucial to consider the organisational context/type within which strategies may be implemented. By reflecting upon the interaction between innovation attributes/characteristics and the organisational context, Wolfe argued that this would increase the generalisability of research findings.

Although my research was not aligned to diffusion of innovation theory as an overarching theoretical framework, I felt that Wolfe's critique provided me with an effective means of reflecting upon my research findings. The conceptual framework underpinning the data chapters lent themselves well to a discussion around (a) the characteristics of the organisation within which the smoking cessation services were implemented (i.e. primary care) and (b) the characteristics of the smoking cessation strategy. Chapter nine (Discussion), therefore, discusses many of my key research findings within this framework.

# CHAPTER FOUR

## Setting the context (pre-data chapter)

This chapter sets the structural and strategic context for the four data chapters to follow, and has four aims:

- 4.1. To locate the role of LHCCs in the delivery of primary care services by outlining the structure of the health service in Scotland at the time the fieldwork was carried out.
- 4.2. To describe the initial steps that were taken to get the smoking cessation services ‘up-and-running’ within the Health Board under study.
- 4.3. To provide a brief outline of the smoking cessation services set-up within each LHCC.
- 4.4. To outline the respondent identification labels used in the four data chapters to follow.

### 4.1. Structure of the health service in Scotland (at time of fieldwork)

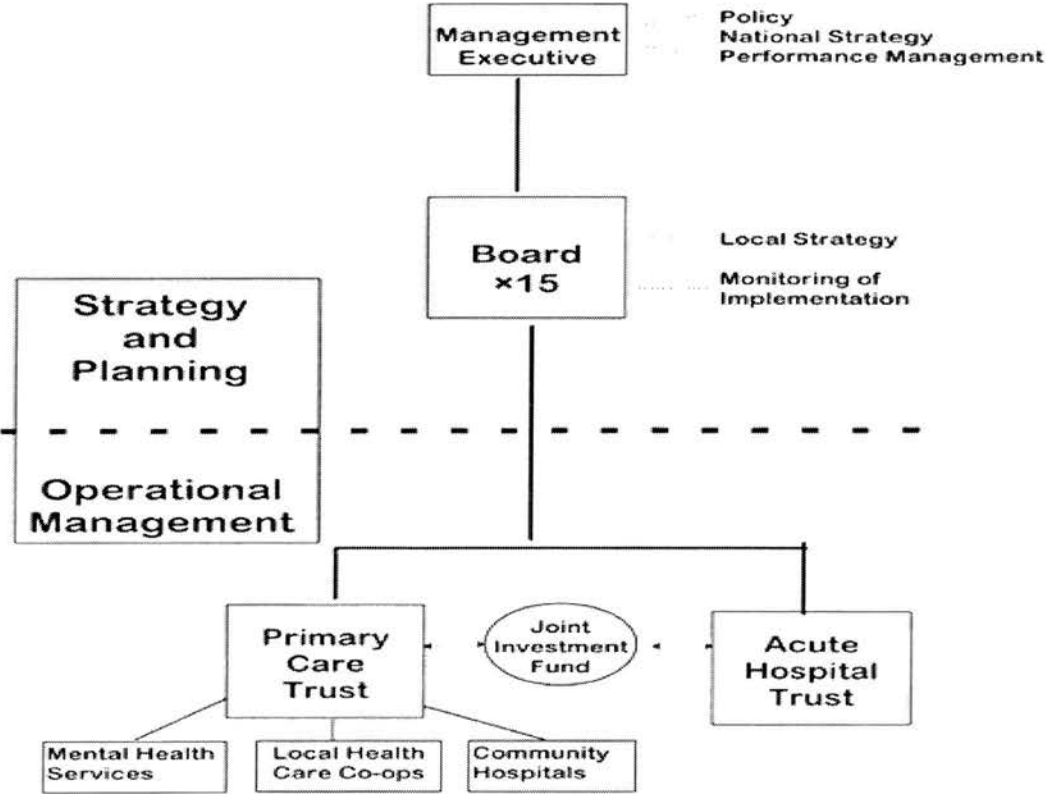
Chapter two (Literature Review) outlined the smoking cessation guidelines, and the blueprint for service development in the UK. The guidelines produced for Scotland (HEBS & ASH Scotland, 2000), closely resembled the *Thorax* guidelines (Raw *et al.*, 1998a), and the broad principles of the smoking cessation strategy in Scotland and England were therefore closely aligned. However, there are several structural differences regarding the organisation of the health service in Scotland that require clarification at this point. The White Paper ‘*Designed to Care: Renewing the National Health Service in Scotland*’ (The Scottish Office, 1998), outlined the structural make-up of the health service in Scotland, as it stood at the time that I conducted my research (*Figure 1*).<sup>1</sup>

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<sup>1</sup> New structural arrangements in the Scottish Health Service are imminent with the formation of Community Health Partnerships (CHPs) for the delivery of primary and social care services.

As is displayed in *Figure 1*, Health Boards in Scotland are responsible for the management of health service delivery within given geographical boundaries. The Primary Care Trust (PCT) facilitates the development of the primary care sector. One of the PCT's principal roles is to implement local health strategies through Local Health Care Co-operatives (LHCCs). LHCCs are responsible for managing and providing primary care services within resource and geographical boundaries, reflecting the priorities of the local areas they represent. They constitute a voluntary organisation of GP practices, and hold a budget for primary and community health services (administered by the PCT), representing a move away from the individual GP practice model, to a more collaborative arrangement.

**Figure 1: Structure of the National Health Service at time of fieldwork**



**Source:** *Designed to Care: Renewing the National Health Service in Scotland* (The Scottish Office, 1999)

Within the Health Board under study in this PhD, there are eight LHCCs (or LHCC equivalents). I have used the term ‘LHCC equivalents’ to refer to those areas that did not constitute LHCCs as such (i.e. were integrated Trusts, which delivered both primary and secondary care services), but still represent defined ‘geographical units’ for the development of smoking cessation services. As discussed in chapter three (Methodology), 7 LHCCs were involved in this research. The profiles of these LHCCs will be discussed shortly, along with the types of services established within each of these areas.

## **4.2. Getting the Health Board smoking cessation service ‘up-and-running’**

The following descriptive account of how the smoking cessation services initially became operational within the Health Board, is taken from an amalgamation of interview data, personal communication with Health Board employees, and Health Board documentation.

### **4.2.1. Early discussions and sub-groups**

The funding for the development of smoking cessation services was available from April 1999. However, 1999/2000 was a time of considerable activity in terms of getting services up-and-running within the Health Board. In the Spring of 1999, a short-life working group within the Health Board provided early direction for the development of local smoking cessation services. In particular, the decision to employ a smoking cessation co-ordinator was agreed upon, and this person came into post in the Autumn of 1999. Following the employment of a co-ordinator, the next significant step was the formation of sub-groups and an advisory group. The aim of these groups was to inform the best ways in which to progress with service development within the Health Board.

Between the Spring and Autumn of 2000, the Health Board’s Tobacco White Paper Advisory Group was active. This Advisory Group involved key representatives from various organisations. These organisations included: the Health Board; ASH Scotland; academia; relevant health professions (e.g. GPs; pharmacy; midwifery); and school nursing. Additionally, in light of the White Paper target groups (young



people; pregnant women; low-income groups), and the place of NRT and primary care in the smoking cessation strategy, five sub-groups were formed. These groups included: a midwifery sub-group (midwifery managers); a young people/school nursing sub-group (school nursing managers); a low-income sub-group (community groups); a pharmacy sub-group (community and hospital pharmacists); and a primary care sub-group (health visitors; GPs; practice nurses). The aim of these sub-groups was to identify the most effective ways in which to develop services in particular settings, and to identify the training needs of different professions. However, as will be discussed in detail in chapter five, service development proceeded to progress within primary care, at the expense of possible service development focussed in other settings (e.g. schools). Development of smoking cessation services within primary care was largely underpinned by Zyban becoming available on prescription from June 2000 (again this will be discussed in chapter five). Following the decision to implement the smoking cessation strategy within primary care, the next stage in service development involved consideration of issues around funding, training, and monitoring.

#### **4.2.2. Funding**

As outlined in *Smoking Kills*, three million pounds was allocated for the development of smoking cessation services in Scotland for a three year period (1999/00, 2000/01, and 2001/02). This funding was subsequently divided between the fifteen Scottish Health Boards. Government guidance subsequently indicated that this £1 million per annum would become part of Health Boards' unified budgets, and would therefore continue to be available (The Scottish Executive, 2001a). In addition to this, additional funding was also provided via the Health Improvement Fund (HIF) from 2001/02. The HIF was established to fund health improvement developments in Scotland, using money generated from tobacco tax. This provided an additional £750,000 per annum for the development of smoking cessation services in Scotland (The Scottish Executive, 2004b). Since the fieldwork was conducted, however, a significant increase in resources has been directed at smoking cessation services, and this will be discussed in further detail in chapter nine (Discussion)

With regard to the Health Board participating in this research, the *Smoking Kills* funding was allocated to LHCCs (predominantly on a per-capita basis). Six of the LHCCs received between £6,000- £11,000 per annum for the development of local smoking cessation services, whilst one LHCC received approximately £25,000. In addition, funding that was originally set-aside for the NRT voucher scheme was re-distributed amongst the LHCCs to fund cessation services, once NRT became available on prescription.

#### **4.2.3. Training**

Training for health professionals undertaking smoking cessation interventions was initiated in the late Autumn of 2000 onwards. This training involved a range of primary health care professionals, including health visitors, nurses, GPs (minority), practice nurses, and pharmacists. Between October 2000 and December 2001, between 300 and 400 healthcare professions were trained in providing brief interventions, and just over 200 were trained in providing in-depth interventions. As a key part of the NHS smoking cessation strategy, training provision has been an ongoing activity within the Health Board. The initial batch of training was completed in the Autumn of 2000, which meant that smoking cessation services could essentially become operational within the LHCCs from this point.

#### **4.2.4. Monitoring/Audit**

As outlined in chapter two, The Scottish Executive specified a requirement for basic data from Health Boards regarding the number of clients using services, user characteristics, intervention type, and smoking status post-intervention. However, unlike in England where a central monitoring system was established from the outset, Health Boards in Scotland were assigned responsibility for developing their own audit/monitoring forms. Health professionals providing smoking cessation interventions were required, initially, to conduct the one- month and three-month follow-ups, then return the monitoring forms (designed by the Health Board) to the Health Board for a six-month and twelve-month follow-up. However, due to difficulties (e.g. time/logistics) experienced by health professionals in conducting the

follow-ups at both one and three months, the Health Board subsequently undertook responsibility for conducting the three-month follow-up.

#### **4.3. LHCC profiles and smoking cessation service development**

'Guides' were drawn up by the Health Board for use by health care professionals in primary care who had received training, and would be providing smoking cessation support. The Health Board Guides broadly reflected the content of *Thorax* guidelines (Raw *et al.*, 1998a) and the smoking cessation guidelines for Scotland (HEBS & ASH Scotland, 2000). These Guides outlined the types of interventions that should be offered to patients, NRT/Zyban guidance, and information around the monitoring/audit of local services. These Guides outlined the stepped-care/motivational approach underpinning smoking cessation services, which subscribed to the Stages of Change/Transtheoretical Model (Prochaska & DiClemente, 1986). The Stages of Change model is a model of behaviour change, that defines the 'change process' according to five key stages: pre-contemplative (not considering behaviour change); contemplative (considering behaviour change but not yet ready to make the commitment); preparation (ready to try and change behaviour); action (behaviour change occurs); and maintenance (behaviour change is maintained for six months or more).

Beyond these 'Guides'/broad framework for the types of interventions that should be offered to patients, LHCCs were assigned responsibility to develop local smoking cessation services as they saw fit, with the funding that was allocated. In essence, therefore, LHCCs had responsibility for developing services that (a) met their own population needs, and (b) were compatible with LHCCs' demographic/structural framework, or particular 'ways of working'.

A total of seven LHCCs were included in this research. The LHCCs were labelled LHCC 'A' - LHCC 'G'. The LHCCs represented different demographic make-ups. Three LHCCs resided within the 'urban/rural' category, whilst the remaining four LHCCs were predominantly 'urban':

**Urban/rural:** Three LHCCs covered a large geographical area. Two of these LHCCs served a population of between 80,000 to 90,000. The remaining LHCC served a population of approximately 150,000. Each LHCC consisted of a combination of both rural and urban communities, and covered a broad socio-economic spread.

**Urban:** Four LHCCs consisted of a predominantly urban area, serving a population of between 70,000 and 110,000. Each LHCC encompassed a wide socio-economic spread, although two in particular had clear pockets of deprivation.

The following LHCC ‘profiles’ provide an overview of the key steps that were taken in the development of smoking cessation services within each LHCC. However, I have not assigned labels to these profiles (e.g. LHCC ‘A’; LHCC ‘B’). The reason for this was that given the unique demographic/geographic structure of some LHCCs, and/or unique approaches to service delivery, LHCCs would be more easily identifiable from the profiles. As these labels are used throughout the data chapters to follow, and also constitute respondent identification (i.e. R1B is interviewee one from LHCC ‘B’), I felt that labelling the profiles might unnecessarily jeopardise respondent anonymity. However, I felt it was important to provide a background to service development within the LHCCs, in order to set the context for the data chapters to follow. The profiles are categorised according to the urban/rural distinction.

#### **4.3.1. Urban / Rural LHCCs**

##### **Profile one**

Several years prior to *Smoking Kills*, a health visitor within this LHCC was involved in providing smoking cessation support locally. This health visitor was approached by the LHCC’s General Manager when the *Smoking Kills* funding became available, to consider the possibility of establishing a more structured smoking cessation service. The senior health promotion worker was involved in the early stages of service development, although service responsibility/co-ordination lay predominantly with the health visitor. A Lead GP and the primary care pharmacist were

involved in an advisory/consultative role, particularly regarding the issue of NRT and the LHCC's drug budget. Initially, GPs referred patients to the health visitor, although as demand for the service increased, a multi-agency approach was adopted. This involved the training of a range of professions including practice nurses, health visitors and pharmacists. Given the influx of referrals, it was recognised that a central system of co-ordination was required for group support. A system of motivational screening was established within this LHCC to manage the waiting lists. The LHCC offered a combination of practice-based (predominantly one-to-one) and centralised smoking cessation support (predominantly groups).

### **Profile two**

Following the allocation of *Smoking Kills* funding, the Development Manager of this LHCC undertook the initial lead role in the development of local services. This responsibility was, however, delegated to the Public Health Practitioner in the early stages of service development. The Senior Health Promotion Specialist was involved in an advisory/consultative role, as was the primary care prescribing advisor (to advise on the NRT budget). Training of health professionals within the LHCC was undertaken. However, there were difficulties in establishing a co-ordinated service within this LHCC due to its geographical diversity. A Practice Forum of GPs was formed to decide upon the most effective way in which to develop/deliver the LHCC smoking cessation service. The funding was perceived to be inadequate by GPs to develop smoking cessation services. Funding was, nevertheless, allocated on a practice-basis. Services within this LHCC were therefore practice-based. However, due to a lack of service co-ordination, there was no clear picture of how many practices were offering support.

### **Profile three**

This LHCC had been active in providing smoking cessation support for a number of years prior to *Smoking Kills*, although this support was provided predominantly within secondary care. Early smoking support was undertaken by a cardiac nurse, and efforts were made to involve GPs in referring patients for smoking cessation support. A Tobacco Issues Group was established within this LHCC in 1992/3,

which raised the profile of smoking issues locally, and supported the development of a tobacco worker's post. This tobacco worker was involved in providing smoking cessation support from 1994/5. Therefore, at the time *Smoking Kills* was published, a framework was in place for developing smoking cessation service locally, and tobacco issues were clearly on the LHCC's agenda. Given the active role of the cardiac nurse and the tobacco worker in developing/delivering smoking cessation services, they effectively undertook the role of smoking cessation service co-ordinators locally. Given that *Smoking Kills* funding was intended to support the development of 'new' services, primary care became the focus of service development within this LHCC. One Locality manager was identified as key in facilitating the release of health visitors for smoking cessation training. Health visitors constituted the key source of smoking cessation support provision within the LHCC. Smoking cessation support was provided in the majority of health centres throughout the LHCC. A key component of the smoking cessation service provided within this LHCC was its focus on the three target groups, particularly low-income. The aim was to establish a low-threshold service, in order to make the service as accessible as possible. The LHCC was also progressive in developing a community pharmacy scheme for pregnant woman, and in being awarded funding for a pilot project involving young people.

#### **4.3.2. 'Urban' LHCCs**

##### **Profile four**

At the time *Smoking Kills* was published, this LHCC had an established Public Health Forum within the LHCC. Smoking cessation was one of the five priorities of this Forum. When the *Smoking Kills* funding became available, a protocol was drawn-up to outline the best way in which to progress with service development locally. The Development Manager of the LHCC assumed early responsibility for overseeing/co-ordinating the development of local services, and the Public Health Practitioner shared in this responsibility when s/he came into post at a later date. The key aim underpinning service development was to ensure that every practice within the LHCC had a staff member trained to provide one-to-one support, whilst the



LHCC would provide centralised group support. A smoking cessation sub-group was formed to co-ordinate the effective implementation of the local smoking cessation strategy. This sub-group included the Development Manager, the public health practitioner, a GP, two health visitors, the lead community pharmacist and a practice nurse. Service structure was such that several practices provided one-to-one support (predominantly health visitors), whilst the LHCC offered centralised group support. Pharmacists became involved in providing intensive smoking cessation support at a later stage of service development, and were used as a dedicated resource for providing continuous group support within the LHCC. A clerical worker was employed on a part-time basis to co-ordinate the referrals and provide administrative support.

### **Profile five**

At the time *Smoking Kills* was published, the primary care pharmacist within this LHCC was seeking ways in which to develop the community pharmacist's role. Smoking cessation was considered by this individual to be an amenable service within community pharmacy. Following the allocation of *Smoking Kills* funding, the primary care pharmacist approached the LHCC General Manager to take these proposals forward and undertook the role of smoking cessation co-ordinator. Training initially started with pharmacists, although as demand for the service increased, other health professionals within the LHCC were also trained. The LHCC offered a combination of practice-based support and centralised LHCC-based support (predominantly group support). Some Practices opted to provide in-house support, whilst others opted to refer patients centrally for group support. Smoking cessation support was provided by pharmacists, health visitors, practice nurses, a community psychiatric nurse (CPN), and a specially employed smoking cessation nurse. This LHCC offered a 12-week smoking cessation support program, whereas other LHCCs adopted a standard 6-week format. As demand for the service increased, this LHCC established a system of motivational screening, in order to filter out the least motivated smokers.



### **Profile six**

Responsibility for service development within this LHCC resided with the Development Manager. The Development Manager in post at the time I conducted my fieldwork, however, was not the same person who was in post during the early stages of service development following the allocation of *Smoking Kills* funding. This LHCC was described as traditionally operating on a practice-basis. The *Smoking Kills* funding was therefore allocated on these grounds, with each practice funded to provide 3 hours of smoking cessation support per week. All practices within the LHCC had a trained health professional (health visitor; practice nurse; other nursing/practice staff) to offer this support via GP referrals. All practices opted for one-to-one support, except one, which offered both one-to-one and group support.

### **Profile seven**

Prior to *Smoking Kills*, there was little smoking cessation activity within the LHCC. The Development Manager took the lead role in the development of the local service. It was decided early on that the most effective use of the funding would be to ‘pool’ resources and provide a centralised LHCC-based service, rather than have practices provide in-house support. A part-time smoking cessation co-ordinator was employed to co-ordinate the referrals from GPs, and to assess patient suitability for intensive support via a motivational interview. Group support was provided (predominantly) by the smoking cessation co-ordinator and one health visitor, although other LHCC staff were in the process of undertaking training and providing support. A dedicated smoking cessation facilitator was employed on part-time basis in 2002, to provide intensive smoking cessation support for one/two days per week.

## **4.4. Respondent identification labels**

The following labels have been used with the data extracts in the four data chapters to follow:

- **Int:** Interviewer/myself
- **Service Delivery:** Interviewees involved in delivering smoking cessation services (e.g. health visitors, practice nurses, pharmacists)

- ***LHCC Management/Strategy/Co-ordination:*** Interviewees involved in a management/strategic role within the LHCCs (i.e. Development Managers; Public Health Practitioners; Clinical Directors), and those who undertook the role of local smoking cessation co-ordinator.
- ***Health Board:*** Health Board staff
- ***Advisory Group:*** those interviewees who were members of the Advisory Group for the Health Board's Tobacco White Paper Advisory Group.

The aim of this pre-data chapter was to set the context for the four Data Chapters to follow. It has outlined the structural framework of the Health Service in Scotland at the time the fieldwork was conducted. This has acted to locate the LHCCs, which are the focus of this thesis, within this structure. The key steps that were taken to progress service development within the Health Board has also been outlined. Finally, the LHCC profiles provide a background to the demographic make-up of the LHCCs, key steps involved in early service development, and the predominant systems of service delivery. This chapter, therefore, places the data chapters within a broader contextual and strategic framework.

# **CHAPTER FIVE**

## **Service Development and LHCC Capacity**

This chapter discusses smoking cessation service development across the LHCCs. It focuses on the key issues that influenced and shaped service development. The first part of the chapter discusses the overarching issue pertaining to the prioritisation of smoking cessation on local LHCC agendas, and implications for service development. The second part of the chapter then focuses on the influence that the availability of NRT and Zyban (Zyban in particular) on prescription had on demand for, and subsequent development of, smoking cessation services at the local level. The final section of the chapter considers the ways in which services were developed within each LHCC, and discusses the factors underpinning different methods of service delivery. The format of the chapter is therefore as follows:

**5.1.** Prioritisation of smoking cessation within the LHCCs

**5.2.** Zyban and NRT: demand-led service development

**5.3.** LHCC service development and delivery

**5.4.** Chapter Summary

### **5.1. Prioritisation of smoking cessation within the LHCCs**

The priority that was assigned to smoking cessation, and where it was perceived to sit on personal/professional and national political agendas, is discussed in chapter six (Personal and Professional Commitment) and chapter six (Strategy Interpretation). This section addresses the issue of commitment to smoking at the LHCC level. In doing so, it considers the priority that was assigned to smoking cessation by LHCCs, the status of smoking cessation on local agendas, and how this was perceived as impacting upon service development.

According to respondents there were varying degrees to which smoking cessation was prioritised within the LHCCs. The priority assigned to smoking cessation

locally was perceived as impacting upon the ease and pace at which smoking cessation services were developed. This local prioritisation of smoking cessation was discussed by one Health Board employee:

**R2H:** Some LHCCs were slower to come on board than others. They varied quite a lot, for example, one of them had identified smoking as a priority in their Health Promotion sub-group, and because that came from sort of top-down, there was more interest in attending training. And, as I say, that LHCC has always been quite keen to get people on-board. **(Health Board)**

There were two LHCCs where smoking cessation was described by R2H as being high upon the local agenda. One of these LHCCs (LHCC 'B') is specifically referred to in the above data extract. The Health Promotion Group, which subsequently changed its name to the Public Health Forum, was a multi-disciplinary group within this LHCC (LHCC 'B'). This group met on a regular basis and had developed key priority areas, with smoking cessation being one of these priorities. R2H went on to describe the impact of agenda-setting on service development within this LHCC:

**R2H:** So that made it much easier, because the interest had come from them, rather than us sort of saying 'do you want to come on-board?' So it's always, if you like, had a Locality approach to it [smoking cessation]. So if an individual Practice...I mean what we're trying to do is get a whole range of people trained to offer brief intervention, and a smaller number of people for [one/two words?] in-depth support. So [LHCC name] I think quite quickly, if they didn't have somebody in the individual Practice who could offer in-depth support, they had a mechanism for referring people centrally. So it's, if you like, an LHCC approach, whereas some other LHCCs didn't have that, so just sort of piecemeal service-you might find that in one Practice they had somebody who could do in-depth support, but others didn't, and if you didn't [few words?] Practice that didn't have it, well then there wasn't anywhere you could be referred. But I think that's because maybe it wasn't sort of taken on board at managerial level in the LHCC, in the same way that it was in [LHCC name]. **(Health Board)**

R2H argued, therefore, that a more comprehensive approach to smoking cessation service development was facilitated by the identification of smoking cessation as a priority at management level within the LHCC. Indeed, a health professional within LHCC 'B', reflected upon the impact that this group had on service development:

**R3B:** And we had a link with health promotion –[name]- if you...she's not longer in the unit, but she used to come to the meeting. We had a GP, and without a lot of theory people were just looking at practical problems that could be dealt with in the Public Health Forum, that weren't being dealt with in any other groups. And we looked at improving uptake of women attending for breast screening- which could have been in another forum, but it just happened that the Public Health one...and then there was this idea about trying to look at smoking with pregnant women, and then we began to look at 'well, lets raise the profile of smoking cessation across the LHCC'. So this is a wee groups all getting together...

**Int:** So this is prior to the White Paper coming out?

**R3B:** White Paper was out....?

**Int:** 1998 that was.

**R3B:** '98, no, the White Paper was out, but it was round the same time. So we had a group of interested people, and we had [Health Promotion link person] who had links with [Health Board]. So the training was quite easily negotiated with [smoking cessation co-ordinator]- it's all about people, never mind place, it's who you know. **(Service Delivery)**

According to respondent R3B, there was background work being carried out by the LHCC around the time of the White Paper being published, which informed efforts to advance the issue of smoking as a public health concern within the LHCC. There was therefore a framework in existence, within which smoking cessation service development could be accommodated following the allocation of the White Paper money. One of the perceived benefits of having this structure in place, as outlined by R3B above, was the facilitation of staff training through the 'link' person.

Another LHCC (LHCC 'G') within the Health Board has also made some headway in developing local smoking cessation services prior to the White Paper money being allocated. This LHCC was widely considered by respondents across all LHCCs to be the most advanced LHCC in making progress in smoking cessation service development. The success in service development was attributed by respondents within LHCC 'G' to strong support from management, and the input from key staff who were keen on raising the profile of smoking cessation within the LHCC. The following extract is taken from an interview with a Health Board employee. This

respondent reflects on the prioritisation of smoking cessation within the LHCC, and the “structures” that were in place to support the development of the local service. The key “structures” referred to in the data extract below include the pre-existence of a tobacco worker, and tobacco-related activity within the LHCC prior to the White Paper:

**R2H:** [LHCC name] has always been ahead, because that's had support- I mean just the structures are different, and because they've had a Tobacco Issues worker in post for quite a long time, and [one word?] groups, which kind of oversee his work. It's just always been an interest at the top, and partly, I think, the former Chief Executive of the hospital was involved in the Tobacco Issues Group. So, the interest has been top-down. They found funding and things, so that was different. So yes, a big difference, a big difference in approach and, I suppose, prioritising in different LHCCs. **(Health Board)**

According to R2H, for a period of five/six years before the White Paper was published, there had been specific activity around smoking cessation within this particular LHCC. Some of this activity is described in the above extract. Since 1993, the LHCC had a dedicated smoking cessation nurse, who had negotiated time to provide support (both groups and one-to-one) within one of the main hospitals in the LHCC. This had been facilitated by the Chief Executive (who was interested in tobacco issues) and management at the hospital. Furthermore, before *Smoking Kills* was published, this particular smoking cessation nurse had been able to negotiate the availability of cheaper NRT for patients receiving support. This was achieved by drawing up a protocol with pharmacy. Accessing cheaper NRT was a fairly progressive step for smoking cessation at this time, particularly as it was prior to the White Paper, and discussions around accessing free NRT or NRT on prescription.

LHCC 'G' also had an agenda of supporting low-income groups. The provision of cheaper NRT was one aspect of this agenda, and was also compatible with the aims of the White Paper *Smoking Kills*. The White Paper highlighted low-income groups as a key target population, and recognised the importance of access to NRT for this particular group of smokers. When the White Paper was published in 1998, therefore, a smoking cessation service was already operating, and according to

respondents like RG2, tobacco issues were clearly on the LHCC agenda and supported at the management level:

**R2G:** I think at the time of the White Paper I was probably doing two days a week smoking cessation full time. There was no real...uh my own structure, but no real structure within the Trust or any kind of backing, except the Tobacco Issues Group, which our former Chief Executive chaired, and they covered not just smoking cessation, but any issues surrounding tobacco in [LHCC name]. So, although I was probably the first to start smoking cessation formally, there was a good foundation there and a great resource within the Trust. **(LHCC Management/Strategy/Co-ordination)**

The Tobacco Issues Group was formed in 1992. The group evolved from a Forum conducted by the LHCC's Drug and Alcohol Concern group. The aim of the Tobacco Issues Group was to promote the issue of tobacco locally, and raise its profile within the LHCC. A Tobacco Worker's post was created in the LHCC in 1994 to facilitate this. The work that this employee carried out included a mapping exercise of the smoking cessation work that was going on informally within the LHCC:

**R1G:** When I came in we were told there were a lot of services in [LHCC name]. So one of the first things I done was a mapping exercise, and at that time...looking from the outside it looked as though there were three or four practices providing smoking cessation, but when you looked...none of them had provided any groups within the last six months, and only one practice that I knew of was providing one-to-one support, and that was in [Practice area name], and they continue to provide that. So, it's almost like...as demand...you know, if there's demand we'll do it, but nothing was done though to market the demand. So at that time we got about trying...to see people...eh first started our clinic in [Practice area name], we were told there was no demand for smoking cessation, but it was a really deprived area, so that was the kind eh...rationale for that. Eh, and I ended up getting...by the end of the clinic, over fifty referrals a month for smoking cessation. **(LHCC Management/Strategy/Co-ordination)**

The same respondent later noted:

**R1G:** So that was probably about '94/'95 that was kind of happening. It wasn't, you know, we were trying to develop the



services, show the need, meet the need, but trying to put the basics in place for the White Paper. (**LHCC Management/Strategy/Coordination**)

In the previous data extract, R1G indicates that the LHCC was keen to target low-income groups. Indeed this was described as a continuing aim of this LHCC as the service developed following the White Paper. The tobacco issues worker, and the smoking cessation nurse worked in close partnership in the early stages of developing local services. Together, they carried out a significant amount of the smoking cessation support, and/or co-facilitated groups with other service providers within the LHCC. The mapping exercise appeared to facilitate the harnessing of piecemeal work that was being carried out on smoking cessation in different areas within the LHCC, and to co-ordinate it more effectively. This was perceived by respondent R1G as useful preparation for service development following publication of the White Paper. Also interesting was the suggestion by R1G that demand for smoking cessation could be *created*, if it was marketed. Section two of this chapter, discusses that the availability of NRT and Zyban on prescription was one key factor perceived to underpin service development in primary care through increasing a demand for services. However, as R1G suggests, “demand” could be *created* in the absence of the availability of these drugs to attract smokers to services.

A further step that was taken pre-White Paper in this LHCC, was to try and involve GPs in the smoking cessation service. Although the attempt to involve GPs in the smoking cessation service was perceived by respondents as a slow process, some claims for its success were made:

**R2G:** Prior to the White Paper I'd tried to get GPs aware of the service by writing to them, saying I'd been seeing their patients, I was starting them on patches, even though they were buying their patches from me, because they weren't prescribing them at that point. But just...informing them that I was obviously giving them a drug, but also em...I did try to put in a kind of smoking history there, teaching them, and things like how many cigarettes they smoked, times for cigarettes, how many times they'd tried to stop, and tried to give them a feel of how to take a smoking history...and...it was quite [one word?]. Then when I started getting referrals from the GPs, actually there's a little smoking

history in there, so it was a very very slow process kind of trying to change their opinion of smoking cessation. (LHCC Management/Strategy/Co-ordination)

According to respondents, the profile of smoking cessation was raised within LHCC 'G' prior to the White Paper, and efforts to maintain its profile appeared to be an ongoing process. Hence, because the White Paper was very cessation orientated, a 'Trust Cessation Group' in LHCC 'G' was formed. Respondents described this as an effort to focus attention on cessation compared to the work of the Tobacco Issues Group, which addressed wider tobacco issues. Furthermore, in line with the White Paper, this LHCC highlighted the three target groups (young people, low-income groups, and pregnant women) clearly on their smoking cessation agenda. As described previously, this LHCC focused efforts on targeting smoking cessation services at low-income groups. Additionally, more than was apparent in any other LHCC, strong inroads were made into targeting young people and pregnant smokers. An example of this was that the Tobacco Issues worker carried out work with young people in schools. This work was claimed by respondents as supporting a successful bid for funding from HEBS and ASH for a pilot project on tackling smoking in young people.

In terms of targeting young people and pregnant women, it is also useful to consider the integration of a major Health Board smoking cessation pharmacy-based project within LHCC 'G'. This project was a separately funded smoking cessation project, and employed pharmacists to deliver smoking cessation services aimed specifically at young people and pregnant smokers. At the time of this project, the LHCC had already been focussing on the role of community pharmacy in targeting young people and pregnant women. The following extract from an interview with R2G reflects on the pharmacy project, and how it was accommodated within existing structures, ways of working, and LHCC objectives:

**RIG:** So we worked with [name-Health Board employee], and [name] is part of our group [smoking cessation short-life working group], so we're now much more able to engage. This is an example of it, because this [pharmacy project] has been really focussed at Community Pharmacy, which is very appropriate.

We'd already been working through community pharmacy for...I suppose adults in general, um...and it was really important in supporting and engaging in this process. It wasn't just pharmacists doing something in isolation, it was fitting into our strategic framework and networking that we'd done. **(LHCC Management/Strategy/Co-ordination)**

Respondent R1G went on to add:

**R1G:** So, I guess it was...it's doing it into the (knitting?), as opposed to having projects sort of parachuting in, so that again coming back to building sustainability by having skills locally, trying to make them as freely available. But it suited us that it was coming on at this time because we'd sort of got the mapping well up and running, and that was sort of developing, and we were discussing how we could target young people, pregnant mums, other groups that we were going to go for, and so that fitted in very well with our objectives. **(LHCC Management/Strategy/Co-ordination)**

There was therefore a perceived compatibility between the aims and methods of the Health Board's pharmacy project, and the objectives of LHCC 'G'. Clearly the pharmacy project was perceived by R1G as an opportunity for advancing LHCC aims to involve community pharmacy in the delivery of local smoking cessation services. The LHCC had also forged strong links with the Health Board, and had a history of partnership working in a range of issues, including tobacco. As indicated by R1G above, this was perceived as being important in facilitating the implementation process.

In addition to having a history of partnership working with the Health Board, LHCC 'G' also had a history of partnership working *within* the LHCC. Tobacco issues were targeted from many angles, including primary care, secondary care, Drug and Alcohol groups, and also the Trust's Council (Local Authority body). Partnership working was described by respondents as crucial in maintaining the profile of tobacco issues, and facilitating service development locally:

**R1G:** And another thing that plays a big part directly and indirectly in smoking cessation in the Trust is the Council.

They've got a very active tobacco policy group. **(LHCC Management/Strategy/Co-ordination)**

RIG went on to reflect upon the benefits of the Council's involvement, and of partnership working:

**RIG:** Now they sit and they encourage cessation, they fund my post, you know, and they try and pull resources, with [pilot project name] for example, they paid for so much of it, the Trust paid for so much of it, I designed it- that's the Drug and Alcohol Service's contribution. So, that whole kind of partnership encourages folk to move forward together, or one partner pulling somebody forward, then the other one having a wee shot at that, and takes everybody out of their zone because the boundaries go down, you know. I think that's slowly kind of driven it, and if...I imagine if cessation services were starting to be reduced, then that would be something for them [the Council] to kind of lobby about. **(LHCC Management/Strategy/Co-ordination)**

Smoking cessation was thus described by respondents in LHCC 'G' as a priority across the board within the LHCC. Tobacco issues, including smoking cessation, were described as receiving support from a range of organisations within the Trust who could work successfully in partnership. The perceived strength of this approach is evident in the above extract, where smoking cessation was described as an issue that would remain on the local agenda.

## **5.2. Zyban and NRT: demand-led service development**

Section 5.1. discussed the status of smoking cessation on local LHCC agendas, and how this was perceived to impact on the development of services. Another key factor that was described as being a catalyst for advancing local service development was the availability of Zyban and NRT on NHS prescription as smoking cessation aids. This appeared to be the case for Zyban in particular, and therefore much of the discussion will be centred on this.

It is noted that the issue of NRT and Zyban is discussed further in Chapter eight (Interventions). As opposed to discussing the role of NRT/Zyban as catalysts for service development, chapter eight focuses on interviewees' experiences of the brief intervention process, and the role of pharmacological support within this process.

Zyban became available on NHS prescription in June 2000, and NRT followed in April 2001. As discussed in chapter two (Literature Review), the updated *Thorax* guidelines (Raw *et al.*, 2000), and the Smoking Cessation Guidelines for Scotland (HEBS & ASH Scotland, 2000), advocated that Zyban be prescribed in conjunction with intensive smoking cessation support. Many interviewees proposed that the availability of this new drug on prescription, and the recommendation that it be prescribed alongside smoking cessation support, was a significant catalyst in service development.

The smoking cessation guidelines (Raw *et al.*, 1998a; HEBS and ASH Scotland, 2000) advocated that the crux of smoking cessation interventions should be the provision of brief advice and follow-up in primary care. However, several interviewees described difficulties in the early stages of service development, associated with the establishment of smoking cessation services within primary care. Several respondents argued that two key (but inter-related) factors facilitated the development of services within primary care. The first factor was that Zyban became available on prescription. The second factor was that the guidelines recommended Zyban be prescribed alongside intensive smoking cessation support.

The following data extract is taken from an interview with a Health Board employee. This respondent was reflecting upon the initial background work that was carried out to determine (a) how the smoking cessation service would evolve within the Health Board, and (b) where the *Smoking Kills* White Paper money would be directed. As the data extract below indicates, discussions were held with a range of different bodies, with primary care being one of these. Additionally, with the three target groups in mind (young people; pregnant women; low-income groups), approaches were made to, for example, midwives, school nurses and community workers. However, as interviewee R1H below intimates, there was perceived to be little interest from primary care in developing smoking cessation services, until Zyban became available on prescription:

**R1H:** [Focus groups were conducted] with midwives to look at how to tackle smoking with pregnant women, school nurses and community education workers to look at how to tackle it with young people, community workers to look at low income groups, pharmacy to look at protocols around the free NRT that was going to be available, and primary care. And those were good, although the message- as you get all the time anyway- 'oh, there's not enough time to do all of this, but it's a great idea'- and it was coming from all of the groups, apart from maybe the young people's group- there was somebody really keen on it happening there. Anyway, we took that back to the Tobacco White Paper Advisory Group, and on the whole they said 'yeah, that's fine, but you might want to change this, that, or the other'. But by the time that came through, that was when they said that Zyban was going to come out on prescription. And lo and behold, suddenly primary care who said 'we haven't got time to do this, we ran stop smoking groups 10 years ago and they were no good', suddenly they were saying 'we need this, we need to get groups set- up, if people are going to get Zyban they have to go through a stop smoking groups', which was the Health Board's guidance. And then they said, 'right, get training up-and-running', and everything like that, and that's how it happened. **(Health Board)**

Zyban on prescription was perceived by interviewee R1H above to be a significant driver behind the development of services within primary care. It is suggested in the data extract above that one of the principal reasons underlying this was concern around the provision of the intensive support to accompany Zyban prescribing. Also highlighted above was 'primary care's' attitude towards the effectiveness of smoking cessation interventions. Respondent R1H proposed that there was a degree of scepticism around the effectiveness of interventions, given previous attempts to provide smoking cessation support in primary care. This suggests that at the time of trying to initiate service development, there may have been a lack of knowledge, and/or acceptance around the updated evidence-base for smoking cessation interventions within primary care.

The previous data extract also touched upon the issue of training. As respondent R1H suggested, there was a perceived need to train staff in providing intensive smoking cessation support. Reflecting upon the impact of Zyban on the development of services within primary care, another interviewee discussed the requirement to build capacity within the primary care sector:



**R2I:** The recommendations from Zyban were very clear, that it worked in conjunction with quite intensive behavioural support. So that again, that raised the concern ‘well how are we [Primary care] going to offer this’, in terms of behavioural support. And that was thrown back to the Board [Health Board], and the Advisory Group [Health Board’s Tobacco White Paper Advisory Group], saying you’ve got to train people and you have to provide the capacity to offer the support, because we have not got the capacity within primary care”. (**Advisory Group**)

Clearly, this respondent perceived Zyban to be a catalyst in the development of services within primary care, particularly in initiating training and capacity-building for the provision of intensive smoking cessation support. Respondents R1H and R2I, cited above, both used the term ‘primary care’. However, primary care encompasses a range of different health professions, with General Practice at the core of service provision. Although respondents R1H and R2I did not specifically refer to GPs, other respondents proposed that the availability of Zyban on prescription encouraged the development of the smoking cessation services at the General Practice level:

**R2G:** When Zyban became available we [LHCC] formed a short life...

**R3G:** Short-life working group...

**R2G:** Or something, yes...which [name] chaired, and...pharmacists involved in it and...

**R3G:** That’s right, I suppose that was the real drive there to GPs to get involved the first time, and the sort of implications of um...prescribing this new drug and all the complex issues around prescribing something...a [health promoting?] drug on prescription.

**R2G:** And I think that GPs had to take notice because patients were actually turning up in their office saying ‘I want this new drug’. (**R2G & R3G: LHCC Management/Strategy/Coordination**)

Interviewees R2G and R3G above, worked within a LHCC that had a secondary care based smoking cessation service in place prior to the *Smoking Kills* White Paper money becoming available. As the White Paper money was essentially made available to support ‘new services’, interviewees within this LHCC suggested that further service developments would have to be out-with secondary care, and most



likely in primary care. As highlighted in the data extract above, Zyban becoming available on prescription was perceived as the catalyst for the service to expand into primary care.

Much of the discussion around the impact of Zyban on service development was underpinned by (a) an increasing public demand for the drug on prescription, and (b) the requirement of GPs to have a support structure in place for prescribing the drug. Many interviewees discussed the increase in demand for services once Zyban was made available on prescription. Given the early stage of service development within the LHCCs, it was reported that services were not adequately equipped to deal with the sudden increase in demand:

**R3C:** We were overwhelmed to start with, because as I say, as soon as people heard there was something on the market that might help them, we were just...everywhere...huge numbers. I mean two/three hundred in a week or so, you know, that sort of number.  
**(Service Delivery)**

Interviewee R2F, cited in the data extract below, highlights how NRT, and not just Zyban, generated this increased demand for smoking cessation interventions:

**R2F:** Largely because of the publicity surrounding the Zyban and NRT, we did get a lot more people interested in dealing with their smoking. And to begin with that worked well, and then what happened was that we built up an enormous waiting list, and that was a real headache. **(LHCC Management/Strategy/Coordination)**

The availability of NRT and Zyban on NHS prescription (particularly Zyban) was, therefore, perceived by respondents to focus the development of smoking cessation services within primary care, and more specifically, within General Practice. The following data extract is taken from an interview with a respondent in a managerial role within one LHCC. This respondent was discussing the impact that Zyban had on the development of smoking cessation group support within the LHCC

**R1C:** August 2000, now you couldn't prescribe Zyban without smoking cessation groups being in existence. So that was part of

the pressure on us as an LHCC to provide these groups, so GPs could prescribe. **(LHCC Management/Strategy/Co-ordination)**

The development of intensive smoking cessation support was a requirement of LHCCs, following the Health Board guidance and allocation of smoking cessation funding. However, respondent R1C's use of the word "pressure" in the data extract above, suggests that before Zyban became available on prescription, there may not have been the same degree of urgency to develop smoking cessation services locally. It appears, therefore, that Zyban was perceived as a key factor underpinning service development within this LHCC.

Interviewee R1F, in the following data extract, described the impact that Zyban had on stimulating top-down pressure for a more structured form of service delivery within the LHCC. Respondents within this particular LHCC expressed strong concerns about prescribing costs. Therefore, having the additional intensive support on offer to patients was perceived as crucial for legitimising and containing Zyban prescribing:

**R1F:** So when the White Paper came out, and Zyban hit the news- it was really Zyban hitting the news that did anything- that was in October 2000. [...] And his [General Manager's] plan was that the GPs in [LHCC name] were asked not to prescribe Zyban, unless there was a back-up of counselling support- either one-to-one or group work. So he really put a ban on GPs prescribing as much as he could. I think the GPs were quite keen to have something really very structured in place. **(LHCC Management/Strategy/Co-ordination)**

The above data extract suggests that, in the early stages, service development within this LHCC was predominantly management-led (General Manager). One interviewee from a Practice in another LHCC, however, reflected upon the direct push from GPs to have a structured service in place to support prescribing. Interviewee R5A cited below described the impact that NRT on prescription had on service development. Respondent R5A worked in a Practice that offered a practice-based approach to smoking cessation. S/he described concern among the Practice GPs that their new NRT prescribing powers would encourage patients to repeatedly consult for different

forms of NRT. R5A argued that as far as GPs were concerned, an offer of some form of additional support, beyond the GP intervention, was necessary in order to prevent this from occurring:

**R5A:** Em...well I think probably about two years ago now, I did the smoking cessation training, the in-depth training, and really to begin with I wasn't doing very much. But shortly after that what happened was, the prescriptions came out, the smoking cessation nicotine replacement therapy came out on prescription. And the GPs came to speak to the health visitors about em- they were a little bit worried that what was going to happen was they were going to be inundated with people who would like prescriptions- 'I'll maybe try the patches, I know that wasn't very good, so I'll maybe try the gum'- and what did they think we could do to help prevent that, what could we put in place? So we had a discussion between us, and we decided to set-up some smoking cessation classes [groups]. **(Service Delivery)**

Clearly NRT becoming available on prescription was perceived by respondent R5A as underpinning the development of smoking cessation services within his/her Practice. S/he described how GPs perceived structured smoking cessation support as being a useful method of managing increased patient demand for NRT products. It is encouraging that the GPs appeared to recognise the potential benefit of non-pharmacological smoking cessation interventions. However, the previous data extract (respondent R5A) also suggests that GPs considered their intervention powers to be limited to drug prescribing, within a medical model framework. Indeed, 'behavioural' support was perceived by R5A to fall within the remit of the health visitors within this GP Practice. R5A also notes in the data extract above that although s/he had undertaken smoking cessation training, little smoking cessation work was carried out within the Practice until NRT was made available on prescription. The reasons for a previous lack of smoking cessation activity were not offered by respondent R5A. However, one health professional, from another LHCC described how being able to "offer" something to patients "made a big difference" to smoking cessation interventions:

**R3D:** Right, the early stages with my own Practice involvement was really because I run a respiratory clinic, and also I see diabetic patients, and you know, you can't do justice to these patients

without bringing up the idea of smoking cessation. So that was how it all started. But at that point there was no...nothing very much we could offer, because there was nothing on prescription. And then when the government decided to make NRT available on prescription, that was really when it all sort of took off, em, in terms of actually getting people to stop, as opposed to just moaning at them, which is what was happening before.

**Int:** So you could offer them something?

**R3D:** Yeah, that's right, and it made a big difference- and Zyban as well...the introduction of Zyban made a big difference as well...because then, actually, when Zyban came out, we had people approaching us. (**Service Delivery**)

Respondent R3D above therefore indicated that the availability of NRT and Zyban on prescription had the following two implications for the delivery of cessation interventions in primary care. First of all, it created a demand for services that had previously been lacking. Secondly, it altered the nature of the relationship between the patient and the health professional. With regard to the patient-health professional relationship, R3D's reference to being able to "offer" patients something, suggests that NRT and Zyban may have acted to legitimise, or 'medicalise', smoking cessation interventions in some way. The increase in demand for services following NRT and Zyban becoming available on prescription, suggests that the offer of a medical intervention (i.e. drug) may have been perceived by patients as being important.

The availability of NRT and Zyban on prescription (particularly Zyban), therefore, was perceived by many respondents as being a major catalyst in the development of smoking cessation services within primary care. Service development following the availability of these drugs on prescription appeared to be characterised by (a) an increased public demand for services, and (b) the requirement for GPs to have structured services in place to legitimise and contain NRT/Zyban prescribing.

### **5.3. LHCC service development and delivery**

As outlined in chapter four (pre-data chapter), the LHCCs varied in their demographic and geographical make-up, and opted for various forms of service delivery. There were three main methods of delivery: practice-based support;

centralised smoking cessation support; combination of practice-based and centralised smoking cessation support. This section will consider the factors perceived as influencing these methods of delivery. It will also discuss some of the key issues that interviewees raised about these different approaches. Table 2 outlines the predominant approach to service delivery adopted by each LHCC.

### 5.3.1. Centralised smoking cessation support and /or combination approach

As outlined in Table 2, two LHCCs opted for centralised group support as the predominant method of service delivery, whilst three LHCCs opted for a combination of practice-based support and centralised smoking cessation support. This combination approach involved practices offering one-to-one support (and occasionally group support), and the LHCC offering centralised (predominantly group) support. Two LHCCs opted for practice-based support, with no centralised group support on offer within the LHCC. The factors described as influencing the development of such models of service provision varied across the LHCCs.

**Table 2. LHCC smoking cessation services at time of fieldwork**

<b>LHCC</b>	<b>PRACTICE-BASED SUPPORT</b>	<b>CENTRALISED GROUP/ONE-TO-ONE SUPPORT</b>	<b>PHARMACY</b>
<b>A</b>	Services delivered on a practice-basis	-----	-----
<b>B</b>	Practices offer one-to-one support	LHCC offers centralised group support	Pharmacists run group support for the LHCC
<b>C</b>	-----	LHCC offers centralised group/one-to-one support	-----
<b>D</b>	Some practices offer in-house support	LHCC offers centralised groups	Pharmacists involved in providing group/one-to-one support
<b>E</b>	Services delivered on a practice-basis	-----	-----
<b>F</b>	Some practices offer one-to-one support	LHCC provides group support	-----
<b>G</b>	-----	Health Centres throughout LHCC offer support (Groups and one-to-one)	Pharmacists involved in LHCC smoking cessation strategy

To reiterate, two LHCCs decided to provide centralised group support, with little or no smoking cessation support being carried out in individual Practices. Respondent R1C from LHCC 'C', below, described the reasons for adopting this model of service delivery:

**R1C:** What we've done in this LHCC is we've generally organised things on an LHCC basis. Not all the LHCCs are like that, some of them do it on a Practice basis, so it's up to the Practice what they do. We've tried to do it on an LHCC basis, so we can share resources and hopefully be able to offer a better service. I mean it's questionable what way you want to do it.  
**(LHCC Management/Strategy/Co-ordination)**

Respondent R1C above highlights how different forms of service delivery may have similar levels of efficiency. However, the provision of centralised group support, as outlined above, was perceived as the most efficient use of resources in this LHCC.

In two LHCCs (LHCCs 'B' and 'F'), it was decided early on that the local service should be structured in such a way that GP practices would provide one-to-one support, whilst the LHCC would offer centralised group support. In LHCC 'B', the decision to adopt this approach appeared to be underpinned by (a) funding, and (b) the guidelines around smoking cessation interventions. The following data extract is taken from an interview with one health professional who provided smoking cessation interventions, but was also involved at a strategic level in service development within LHCC B:

**Int:** So what were some of the things that were taken into consideration when deciding how to set the service up?

**R5B:** The amount of money was small, em...we recognised it was almost imp- that the bulk of the activity would have to be done on an ad-hoc basis within Practices, and it would be impossible to quantify how much work was being done. Em...and so that's why we decided to allocate a certain amount on a capitation basis.  
**(Service Delivery)**

R5B went on to add...

**R5B:** There was a central initiative to have groups, which I had no great enthusiasm for, but we, you know, felt we should go along



with what was being promoted centrally [Health Board]. (**Service Delivery**)

In the above data extracts R5B suggests that funding was one of the key factors underpinning service development within this LHCC. The issue of funding is addressed in greater depth in chapter seven (Strategy Interpretation). The second factor raised by Respondent R5B, above, is the guidance provided by the Health Board for smoking cessation interventions. The smoking cessation guidelines, and the Health Board guidelines recommended the provision of both one-to-one and group support. R5B proposed that this guidance informed decisions to provide centralised group support within the LHCC, in order to adhere to Health Board recommendations. Respondent R5B also detailed the difficulty in ensuring that all Practices within the LHCC provided smoking cessation support, given that smoking cessation support was provided on an ad-hoc basis. Indeed, an interviewee from LHCC 'F' also raised this issue. LHCC 'F' had opted for a similar method of service delivery as LHCC 'B'. Funding was divided between Practices (for one-to-one support) and centralised group support:

**R2F:** Not many practices actually made use of the funding for practices, because, and I think that was partly again, it's fine having...it takes a wee while to set things up, and because there was just such a small amount of money per practice, it really requires having some part-time staff who've been trained, who were willing to do extra. (**LHCC Management/Strategy/Coordination**)

Similar to the experiences of LHCC 'B', respondent R2F above claimed that the limited amount of funding available to individual Practices, resulted in this money not being used effectively at the Practice level.

Respondents within LHCC 'B' discussed how the centralised smoking cessation support offered a service to those who were unable to access a Practice-based service. The provision of centralised group support was perceived by respondents as important for reaching those patients who were unable to access one-to-one support within their Practice. Therefore, it appeared that the provision of centralised support was not only about adhering to smoking cessation guidelines, but also about



providing a service that was accessible to patients, as not all practices offered smoking cessation support.

In LHCC ‘F’, centralised group support evolved as the preferred method of service delivery. This appeared to be underpinned by two key factors. Firstly, the health professional who co-ordinated the service locally, personally favoured group support over one-to-one support as an intervention method. Secondly, group support was perceived by this health professional to be a more effective method of reducing waiting lists.

LHCC ‘D’ also opted for a combination of centralised group support and practice-based support, although this system of service delivery did not appear to be determined at the outset of service development. Instead, it appeared to *evolve* as an approach to service delivery in response to the needs of individual Practices, and patient demand. In the data extract below, R1D describes how service delivery evolved in response to patient demand for services within the LHCC:

**R1D:** I never ever imagined that the service would mushroom the way it did. Em, literally we went from, you know, having one or two patients, to having four hundred on the list, and not really knowing what to do with them. So it’s been one of those things that’s been kind of very much a learning curve for everybody as we’ve gone, and it’s basically adapted to suit the needs of the population as things have grown, and to meet the needs of the Practices as well, in terms of demand. (LHCC Management/Strategy/Co-ordination)

As discussed in section 5.2. of this chapter, the availability of Zyban and NRT on prescription was perceived by some respondents to impact significantly on demand for smoking cessation services. As highlighted in the data extract above, the high demand for services was clearly unexpected, and the local service was perceived as having to evolve in a way that would accommodate this demand. One of the ways in which the service developed within LHCC ‘D’ was through training more staff in providing smoking cessation support. Additionally, a letter was sent to every Practice, to establish how local Practices would prefer to proceed with service delivery. Some Practices opted to provide in-house support, whilst other opted to

refer patients on to centralised group support. It is not entirely clear why some Practices opted to provide in-house support and others did not. However, as highlighted in the data extract below, enthusiasm of Practice staff, and concern around LHCC waiting lists were two reasons implicated in this choice:

**R2I:** Our Practice chose to do it in-house, one because we didn't want...when there was an enthusiasm in our patients once they [NRT and Zyban] came on prescription, the LHCC-model that was adopted in [LHCC name] immediately created a waiting list. So patients would immediately go onto waiting lists, and we didn't really want that to happen. So we- and because people were enthusiastic in our Practice- we did it in-house. (**Advisory Group**)

It was initially the case that those Practices that opted for in-house support, could not refer patients centrally for group support services. This was due to the fact that Practices were paid for providing their own service. However, this was reviewed in recognition (by the LHCC co-ordinator and service staff) of the need to provide an accessible and flexible service for all patients within LHCC 'D'.

Although the majority of LHCCs opted for providing centralised group support (either as the predominant method of service delivery, or additional to practice-based support), there were problems associated with providing this group support. One problem identified was the difficulty in accessing out-of-hours premises. This was a particular concern for running evening groups. The following interviewees discussed the difficulty involved in accessing premises for evening sessions. Although suitable premises were identified, the logistics of conducting group support were perceived to be more difficult than the logistics of providing practice-based support:

**R1C:** There's a problem with premises. In this LHCC we only have one purpose-built Practice [area/practice name]. That is not readily opened in the evening. There's one evening a week when we can ask for porters to be on duty to allow that facility to be used. For some of the time we're using facilities that aren't really suitable, and other times we have to go out and get community facilities. So there would be an argument- yes it's nice for people not to go to the surgery, but it gives you an additional problem. If you want to set up a group, go and find somewhere that's got accommodation at the time you want it, and have the money to pay

for it. I can't say money is the biggest issue, but it's another issue for us. **(LHCC Management/Strategy/Co-ordination)**

Not only was access to appropriate premises perceived as problematic, but respondents also described difficulties in finding staff who were prepared to provide group support on a flexible basis. This was reported as a particular problem within LHCC 'F', due to the preferred working methods of staff. Specifically, staff within LHCC 'F' were described as preferring to work within their own practice area. They were described as reluctant to provide evening groups in other areas within the LHCC. As the following extract suggests, this created service delivery problems, particularly in areas where there were a limited number of staff trained to provide smoking cessation support. The interviewee cited below was discussing the method of providing support that was used within LHCC 'F'. This method involved providing smoking cessation groups on a Locality-basis (i.e. different localities/areas within the LHCC).

**R1F:** So yes, having the patients in localities was good. But one of the disadvantages of that was that the staff then just wanted to do their own patch. So if the health visitors in [area name] were trained up to be Stop Smoking facilitators, they could in fact actually go anywhere in [LHCC name], but they began to dig their heels in and say 'no, we're only going to see [area name] people'. **(LHCC Management/Strategy/Co-ordination)**

Given that some areas did not have trained staff to provide smoking cessation support, this led to lengthy waiting lists building-up:

**R1F:** And so some waiting lists for some areas build-up very high, for instance in [area name], there's not a group facilitator in [area name]. There's a health visitor who does one-to-one, so you can imagine- and she's only part-time- so she can't see many people. So, the list grows enormously **(LHCC Management/Strategy/Co-ordination)**

As highlighted above, some areas within LHCC 'F' lacked trained staff to provide smoking cessation support. Although not covered in the data extract above, this variation in the availability of staff may relate to issues of staff interest and

enthusiasm, which is discussed further in chapter six (Personal and Professional Commitment).

Another problem with the centralised group support described by respondents was the co-ordination of prescription requests. Centralised smoking cessation groups included patients from a number of different practices within the LHCC. The following data extract is taken from an interview with one health professional, who worked in a Practice that had opted to carry out its own smoking cessation support within the LHCC. It highlights some of the key issues that interviewees discussed around co-ordinating prescriptions for group support:

**R2I:** And the practical issues of if patients did come to a group which was set up and run by, for an example, a nurse who'd been trained to run the group, there'd be patients from maybe ten different practices. How do you then organise a prescription, because the nurse can't write the prescription, if they weren't nurse prescribers- and they couldn't anyway because they're from different practices. So she had to then phone up Practices and try and organise prescriptions over the phone. It was...she...you know, just time-consuming, and a bit clumsy, and patients would come to a group, and quite rightly, expect that they get their prescriptions for nicotine replacement therapy [one/two words?] actually come, and then [name] had to go and chase up the doctors. And that's why we didn't join it [LHCC-based approach], because it was much easier to just do our own. (**Advisory Group**)

This section has discussed the factors underpinning the development of LHCC smoking cessation services that involved centralised group support. Additionally, it has highlighted some of the key difficulties and issues that were perceived to be associated with this approach. Two LHCCs, however, opted for a practice-based approach to smoking cessation, where there was no form of centralised group support within the LHCC. The factors underpinning this decision varied between the two LHCCs. Additionally, the experiences of running a service using this approach, compared to a centralised group support, appeared to be quite different.

### 5.3.2. Practice-based support

LHCCs 'A' and 'E' opted for a practice-based approach to smoking cessation. Within LHCC 'E', every GP practice offered smoking cessation support as predominantly a one-to-one service. The decision to adopt this approach could not be clarified in interviews with those involved in the early stages of service development, as a key worker was no longer in post at the time of conducting the interviews. However, from interviews with health professionals who provided support for the service, it appeared that the practice-based approach was a characteristic 'way of working' within LHCC 'E'. Throughout the interviews with health professionals from this LHCC, there was little discussion of formal deliberations around service progression in the early stages of service development. The following data extract is taken from an interview with a health visitor who provided one-to-one support within her Practice. In the extract the respondent intimates a preferred working style of Practices within this LHCC:

**R4E:** The Practices tend to be quite inward looking, rather than sort of looking and seeing sort of their public health remit. There is various smoking cessation work that goes on at the [local project], and it's in [practice area name]. But their tends to be run during the day as well, you know, and our population here are mostly employed, therefore we do need some sort of facility that is available to them after, you know, after work. **(Service Delivery)**

R4E suggested that the potential to tap into additional resources within the LHCC for service delivery would be beneficial. However, the comment that "*Practices tend to be quite inward looking*", suggests that a joined-up approach was not a preferred way for practices to operate within the LHCC. However, interviewee R4E went on to discuss some of the perceived benefits of an LHCC-based approach to smoking cessation, as opposed to the practice-based approach:

**R4E:** We hear different ideas on what works well, some place else etc, and I think the sort of core waiting list as an area, that seems to be happening in [LHCC name], where they run groups and everybody from all the practices sort of just get places as they come up, I think that must free up a lot of individual practices' time, you know, be it health visitors, be it practice nurses. **(Service Delivery)**

Although the centralised-group approach was perceived by R4E to have benefits in terms of alleviating the pressure on Practice staff, those health professionals who operated on a practice basis also spoke of the practical benefits of this using this approach. In particular, there was a perception that it was easier to co-ordinate a practice-based service. Co-ordination difficulties included finding premises, co-ordinating referrals (as discussed previously in this section), and managing waiting lists:

**Int:** And how easy was it to get the service started initially?

**R2E:** It was, once I'd done the training it was just a matter of getting the, having a room, and getting referrals from the GP, and that happened, there was no difficulty in that. **(Service Delivery)**

**R3E:** So it wasn't difficult, because it's just incorporated into our everyday clinic. So we weren't setting up a clinic, we weren't looking for rooms, you know, we weren't needing any other help. We really just incorporated it, and if patients asked- or a lot of patients...we were already seeing for things like coronary heart disease management, hypertension, for diabetes, the registration medical, asthmatics- all these patients, when they saw us for that particular disease, you know...clinic...we discussed if they were smokers- we discussed it then. So we put a lot of people into smoking cessation clinics from...or smoking cessation appointments...from seeing them in clinics. **(Service Delivery)**

Interviewee R3E above discussed how much of the smoking cessation support provided in the Practice was accommodated within the Practice's existing chronic disease management (CDM) framework. It did not appear, therefore, that incorporating smoking cessation support within the Practice, was perceived by R3E to be a difficult process. Respondent R3E did, however, discuss problems associated with increasing demand for smoking cessation support, and the time-pressures this placed on the ability to operate all the CDM clinics. However, as the following extract indicates, R3E notes a capacity within the Practice to accommodate this increasing demand. For example, one nursing post was upgraded to absorb the excess demand:

**Int:** You mentioned earlier things like the asthma clinic and things like that...that smoking was kind of taking over. How did you get around that problem?



**R2E:** Well, we kind of...we just brought it to the attention of the Practice Manager, and said 'we feel we're struggling- all we're seeing is smoking cessation'. And at that time there was a little money available. So what we did, one of the nurses was upgraded, to be able to do a clinic, which would incorporate smoking cessation. So her- because she didn't do asthma and other things- she could take on any new people for smoking cessation, which meant that all we were seeing- or myself and my colleague, who do all the other clinics as well you see- were people who'd already been seen by us. **(Service Delivery)**

The health professionals interviewed in LHCC 'E' had quite favourable perceptions of the benefits associated with the practice-based approach. That every practice in the LHCC offered some form of support was appreciated by respondents, who described it as a system that worked well within this particular area.

However, the experiences of respondents in LHCC 'A' appeared to be quite different. First of all, according to respondents the decision to deliver services using a practice-based approach appeared to be underpinned by quite different circumstances. Respondents from LHCC 'A' clearly perceived indecision around the best way for the service to progress in the early stages of service development. One of the difficulties perceived was related to the geographical make-up of the LHCC, in that it covered a large and diverse area. As a result of this, it was proposed that it was difficult to establish one centrally co-ordinated service within the LHCC:

**R3A:** Locally to get the service set-up, em...it was very difficult to pin down exactly what the problem was- we have had trouble here establishing a co-ordinated service, which is universally accessible. Em, given the geographical issues, we couldn't have one central point, because that would mean transport issues for- and if you do want to target low-income people, then you don't want the service twenty miles away, that they can't get there. **(LHCC Management/Strategy/Co-ordination)**

Discussions around how the smoking cessation service should be developed within the LHCC were held as part of a primary care services group (service development group). This group covered a range of primary care issues, including smoking cessation. However, it was intimated by some respondents that the issue of how to take the service forward within the LHCC was never adequately addressed.



Respondent R3A below reflects upon the impact of this group on the service development process:

**R3A:** There was an LHCC group I was part of, looking at primary care service, it was a service development group.

**Int:** About several issues, not just smoking?

**R3A:** Yeah, for any issue that had to do with primary care. So it could have been a service issue, it could have been a health promotion issue, or prevention issue, whatever, em...and it was discussed there. But, for whatever reason, that group never succeeded in taking the issue by the scruff of the neck and getting it...pinning it down [laughing], em...identifying what the problems and issues were, and trying to move it forward. **(LHCC Management/Strategy/Co-ordination)**

R3A continued to describe how the smoking cessation money was allocated:

**R3A:** Ended up dividing the money by head of population for each practice, because it wasn't possible to come to a clear decision about how to spend it. **(LHCC Management/Strategy/Co-ordination)**

One of the reasons described by respondents for the allocation of money at the practice level, was a reluctance of GP Practices within the LHCC to work in partnership:

**R3A:** There has been resistance I think from the GPs that make up this LHCC to doing anything co-ordinated. Em, and even although there was money available, there was a general perception that it wasn't enough money to set up a service, and particularly if you break it down by practice, practice by practice. **(LHCC Management/Strategy/Co-ordination)**

From respondent accounts it was evident that the GP practices within LHCC 'A' preferred to operate independently. The financial aspect of service delivery was perceived as one of the reasons underpinning this. However, with the responsibility for the development of services being handed over to the individual practices, it was argued that this led to variations in the standard and level of services that were delivered by these Practices. One interviewee commented on the lack of direct influence over service development within Practices:

**R4A:** Sometimes you've got to go along with these decisions of...of eh...in this case, the GPs- you know, they decide what the activity is in their practices, so I mean you can influence, but you cannot force decisions on them. **(LHCC Management/Strategy/Co-ordination)**

In contrast to the experiences of LHCC 'E' that had opted for a practice-based approach, there did not appear to be similar success in the establishment of services within GP practices. As the following extract suggests, it was not entirely clear that the money that was allocated to Practices was actually used for developing a comprehensive, local smoking cessation service in all cases:

**R4A:** So some [practices] bought smokilisers, for ad-hoc use, em some bought material, other- to be honest- it just kind of went into the pot, and we didn't get any information back. I think we learned from that experience in that em...there's recognition that you can put money in, but you do need to get some pretty eh robust stuff back out, as to what they actually spend the money on, even though it's a small amount of money. **(LHCC Management/Strategy/Co-ordination)**

**R1A:** I mean some...there's particular Practices who have really gone at it, and quite comprehensibly I think, are providing probably quite a good service for anybody that requires it. There are other places where frankly, you know, they'll probably get prescribed some form of NRT or zyban, or whatever, and the...probably the extent of the smoking cessation support is 'well, off you go, stop'. **(LHCC Management/Strategy/Co-ordination)**

Respondents within LHCC 'A', discussed that keeping track of the smoking cessation activity that was taking place was problematic. Additionally respondents perceived there to be variations in the level of service that was provided within the different Practices. Practice ethos appeared to be one key factor underpinning the types of services that were developed within LHCC 'A'. Two Practices, for instance, demonstrated clear differences in their approaches to tackling smoking cessation. In one practice, the smoking cessation work [groups and one-to-one] was carried out solely by one health professional on a fairly ad-hoc basis. This health professional (R2A) expressed concerns around the sustainability of the local service. This concern over sustainability stemmed partly from the level of funding that was

available, which was deemed inadequate. Additionally, R2A perceived the practice GPs to be sceptical of the benefits of smoking cessation activity to the practice.

The experiences within the GP practice just outlined, contrasted sharply with the experiences of another practice within the same LHCC. The contrasting Practice had a history of working within a community development framework, and was also part of a SIP (Social Inclusion Partnership) area. The smoking cessation service was accommodated within a 'community development' ethos. That is, groups were run in local accessible venues, such as the local SIP office and leisure centre. As opposed to just one health professional undertaking smoking cessation support, the experience of this Practice appeared to be one of shared responsibility for the provision of services. The GPs initially provided the funds for refreshments and stationary, and the delivery of groups/one-to-one was shared amongst several of the practice staff. This made the time-back option a feasible one for recouping the time (and cost) for delivering smoking cessation support, due to there being several staff to share the workload. From respondents' accounts, it appeared that smoking cessation was an issue that had been accommodated within the community development ethos of the practice:

**R5A:** We're quite pleased with the way ours has evolved and the fact that, you know, we have brought- we go out into the community to provide a service, that we've brought other members of the community, like the pharmacist and the leisure centre manager, and the quitter, you know, so em we feel that we're doing our bit for community development and partnership working as well. Yeah, we're very...we think we're quite- we're quite forward thinking here in [practice area name]. **(Service Delivery)**

This integration of the smoking cessation service into the existing working framework of the Practice was also perceived by respondents as ensuring its sustainability. The following extract suggests that smoking cessation would continue to remain a priority within the practice, and that options were available to source funding from several areas, including the SIP:

**Int:** So the situation now, the funding is recurring, is that right?

**R5A:** The situation now- yes, I mean, well, no, not as such, but we feel that because of the SIP, they usually have quite a bit of funding, and we can usually tap into them. And there are lots of different initiatives that you can get funding from now, so we feel that we would be able to get the funding without any difficulty. Em...yeah, I don't think there's a problem, I think there's quite a few different sources that we can get funding from- but it's not ongoing from a particular source all the time, it's just eh...for this year, we should be able to manage. We have got some from [name- public health practitioner] this year, and then em...for the young parents one [smoking service within the practice to target this group], we're hoping to get the money from the SIP. So I think it'll- I don't think there'll be a problem. **(Service Delivery)**

Clearly respondents shared a sense of 'ownership' of smoking cessation which appeared to have become established as a practice priority. Additionally, there was an apparent enthusiasm to seek additional funding for the development of the local smoking cessation service.

Practices within LHCC 'A' therefore had quite different approaches to smoking cessation from LHCC E. It was not entirely clear from the interviews how many practices were offering support within LHCC 'A', and how comprehensive this support was. Respondents from LHCC 'A' commented on a lack of awareness around the work that was taking place in practices within the LHCC. This lack of awareness was attributed to the lack of central co-ordination of services:

**R1A:** I mean one of the problems is we don't have an accurate picture of exactly what's going on. There's never been somebody who's tried to kind of co-ordinate the entire thing, and that's something that we're trying to do just now. **(LHCC Management/Strategy/Co-ordination)**

Respondent R5B, below, posited that delegating the responsibility for the development of smoking cessation services to the individual GP Practice level, was not an effective means of ensuring that services are developed. R5B reflected upon the lack of control that LHCCs may have over individual Practices:

**R5B:** All I've seen at LHCC level is that it's very hard for the LHCC to control what happens within Practices. And Practices,

once things are set in place, are highly effective at doing particular things. **(Service Delivery)**

Respondent R5B posited that a Practice-based approach might only be effective, if resources were directed at each Practice to ensure that a system for co-ordination was in place. Such as system of co-ordination (e.g. a link/key person), s/he argued, would ensure that there was a recognised smoking cessation element within the Practice. Ideally the role of the link person (as argued by R5B) would be to take responsibility for co-ordinating the support that was offered at the Practice. This would involve co-ordinating patient prescriptions if required, as well as being the link between the patient at the Practice who required group support and the LHCC referral system. R5B proposed that having this key link person within each Practice, would be a more effective means of service delivery:

**R5B:** It seemed to me to be a valuable part of the whole process, to have a key person in each Practice, because that was why I thought things really operated under [few words?] sort of person, and I reckoned you don't really know what's going to happen, that you can just light the fuse paper and stand back, and...to have a key person in each Practice just interested, getting things going, keeping it on the agenda within each Practice, was probably rather, you know, likely to be as effective as anything else that you might do. **(Service Delivery)**

This issue of service co-ordination is discussed in further depth in the following section, which focuses on the role of administrative/clerical support and efforts made to co-ordinate local LHCC services.

### **5.3.3. Service co-ordination**

One key aspect of service co-ordination was administrative/clerical support. This was particularly the case for those LHCCs that offered centralised group support, whereby referrals could potentially come from all Practices within the LHCC. The LHCCs that were delivering services via centralised group support had incorporated some form of administration support. This was seen by respondents as invaluable in co-ordinating the referrals, and dealing with the paperwork associated with this method of service delivery. In the following data extract, respondent RIC describes the administrative workload underpinning service co-ordination:

**R1C:** It also has to be quantified just how much admin support is required for running these groups- that has not been identified before. You need some sort of database in the LHCC, a waiting list being monitored, letters being sent out to people, keeping people on and off lists depending on whether they can come or not, setting up the motivational interviews, booking rooms, getting people to actually run the groups, filling in the audit return forms. If it's pharmacists, paying them- paying all the other invoices that come in, sending in the audit forms, reporting back to the LHCCs- all of that, it's sort of been hidden. **(LHCC Management/Strategy/Co-ordination)**

The benefits of a having an administrator in place were highlighted in interviewees' reflections on service delivery issues. The presence of an administrator was clearly perceived to facilitate the smooth operation of referrals and group co-ordination within LHCCs:

**R1B:** We now have an AC support person...secretarial support here- lady comes in five afternoons...Monday to Friday afternoons, and as part- part of her job. We've said 'can you co-ordinate the admin behind the group clinics- organising venues, and letter out to clients and inviting them, and so forth'. So she does that, and that has made a big difference to us as well. **(LHCC Management/Strategy/Co-ordination)**

In LHCC 'B', the person who was employed as administrative support was designated as the smoking cessation 'co-ordinator'. All referrals for centralised group support within the LHCC went through this person. However, the 'co-ordinator' was not perceived solely as the person who provided the administrative/clerical support, but also the person who carried out other key supportive duties within the LHCC. For instance, in LHCC F, the service 'co-ordinator' carried out all the administrative/clerical support, as well as providing group support within the LHCC. In LHCC 'C', the service 'co-ordinator' was perceived by respondents to be the person who carried out the motivational interviews for the LHCC, provided group support for the LHCC, and conducted the one-month follow-ups. The importance of having a system of co-ordination is reflected in the experiences of one LHCC, in the early stages of service development:



**R1F:** We got hundreds of people referred in right away. So within about a couple of months, we were well aware that we would have to have somebody that would manage this whole service- it couldn't just be run...an odd wee person doing an odd wee group. **(LHCC Management/Strategy/Co-ordination)**

Respondent R1F then went on to describe how this problem was addressed. S/he discussed that one key person undertook responsibility to co-ordinate the group referrals within the LHCC. A database was developed by this person in order that referrals could be received, and subsequently allocated to appropriate groups within the LHCC. Co-ordination was therefore considered by many respondents as key in establishing an effective method of service delivery, especially when centralised group support was a feature of service delivery. Respondent R1F perceived that it was necessary for someone to take the reins of local service development/delivery, in order that the service could operate efficiently.

Another important element of this co-ordination/management strategy, however, was the role of smoking cessation sub-groups within LHCCs. Respondents within LHCCs 'B' and 'D' discussed that LHCC smoking cessation sub-groups helped to focus the direction of smoking cessation service development locally. Respondent R1D below discussed how the formation of a smoking cessation group within the LHCC helped to structure local service delivery. This group consisted, primarily, of the LHCC smoking cessation co-ordinator, two GPs, one health visitor, one community pharmacist, and a practice nurse:

**R1D:** So the service is much more structured. I think- what we did half way through was stopped and we just sort of held the reins on it, and got our group together to really discuss where we were going wrong, what needed to be done, and we came up with a very structured referral process, and had, you know, a leaflet that was sent to the patients with a questionnaire before they were allowed to get a place on the scheme so that everybody rally knew where they were. And then we kind of formalised everything, and as soon as we'd done that, it's run much more smoothly. **(LHCC Management/Strategy/Co-ordination)**

In LHCC 'B', a similar smoking cessation sub-group was formed in order to focus and guide service development/delivery. One of the key outcomes of this group was



the development of pharmacy-based smoking cessation support. The involvement of pharmacists in the delivery of local smoking cessation services was attributed by respondents to the influence the Lead Pharmacist who was a member of the smoking cessation sub-group:

**R4B:** He [lead pharmacist] was definitely- he was in the right place, because he was in the management board [for the LHCC], he knew the money was available, he knew that they had a problem because they had this money...that the LHCC was struggling to provide smoking cessation, and therefore was able to use his influence to get it running. He...he proposed the service [pharmacy-based], brought it back to the Locality, which we were keen to do, and went back, and we've now shown that we can provide that, and they're keen to carry it on....I mean the LHCC's keen for us to carry it on- the pharmacists are quite keen as well.  
**(Service Delivery)**

Reflecting upon the impact of a system of local service co-ordination, it is useful to consider the two LHCCs (LHCC 'A' and 'E') that opted for the practice-based approach to smoking cessation. According to respondents, LHCC 'E' experienced relative success in developing smoking cessation services within all of the local GP Practices. The interviews conducted with health professionals within LHCC 'E', suggested that there were key people within each Practices that had taken on the responsibility for co-ordinating and ensuring that a service was delivered. This success was attributed by respondents to the personal interests and priorities of the staff involved. However, LHCC 'A', as discussed previously, fared less well than LHCC 'E'. Respondents in LHCC 'A' discussed a lack of knowledge at management level within the LHCC about the smoking cessation work that was actually being carried out. This raises the question as to why the Practice-based method was perceived to work well in one LHCC, but not so well in another. This difference in the perceived success of service development at the practice level, may be attributed to the lack of an effective system of service co-ordination in LHCC 'A'.

As outlined in section 5.3.2, respondents from LHCC 'A' discussed that no key person was identified centrally to co-ordinate local service development, and to ensure that Practices were developing efficient services. Interviewee R5B, as discussed previously, argued that it was not sufficient to "*light the fuse paper and*

*stand back*", in terms of allowing Practices to develop smoking cessation services of their own accord. Indeed, respondents in LHCC 'A' discussed the difficulties in establishing the smoking cessation activity of local Practices, which was attributed to the lack of central co-ordination of services. Within LHCC 'E', respondents described that a practice-based approach was a characteristic way of working within the LHCC. A system of central co-ordination may, therefore, have been less important for facilitating service development. Additionally, respondents from LHCC 'E' discussed that one LHCC professional (at the LHCC management/strategy level) had the role of feeding information to each Practice, acted as a central point of contact, and also facilitated quarterly meetings with the staff involved in providing smoking cessation support throughout the LHCC. Therefore, although Practices tended to work in isolation, there was a perceived element of service co-ordination at a central level.

A system of co-ordination, at both the central (LHCC) *and* Practice level, was therefore perceived by respondents as an important element in ensuring the efficient development and delivery of smoking cessation services within the LHCCs.

## **5.4. Chapter Summary**

This chapter has discussed smoking cessation service development across the LHCCs. In doing so, it has highlighted the key issues that were perceived by respondents to influence and shape service development, and different methods of service delivery. Section 5.1. discussed the priority assigned to smoking cessation on local LHCC agendas, and the implications for service development. Local prioritisation of smoking cessation, and 'ways of working' were clearly perceived by respondents to facilitate the development of local services in two LHCCs in particular. The chapter then went on to discuss the perceived impact that NRT and Zyban had on the development of smoking cessation services. Respondents clearly perceived the availability of these drugs on prescription (particularly Zyban), to be the catalyst in initiating service development within primary care. Much of the discussion around the impact of Zyban on service development was underpinned by respondent perceptions of (a) an increasing public demand for the drug on

prescription, and (b) the requirement of GPs to have a support structure in place for prescribing the drug. The final section of the chapter considered the ways in which services were developed within each LHCC. This section discussed the factors underpinning different approaches to service delivery, and some of the perceived key issues associated with these different approaches. One of the key issues highlighted in this final section was the perceived value of having a co-ordination system in place for the effective development and delivery of local smoking cessation services.

## CHAPTER SIX

### Personal and Professional Commitment

This chapter discusses the issue of personal and professional *commitment*. The meaning of this concept will become clearer as the chapter progresses. However, I have used this term to encompass the role that enthusiasm for, and commitment to, smoking cessation (both personally and professionally), had in underpinning the development and delivery of the smoking cessation services. This incorporates discussions around whether health professionals viewed smoking cessation as a core part of their work. Additionally, it reflects upon differences between health professions with regards to their perceived role in smoking cessation and health promotion more generally. The chapter format is as follows:

**6.1.** Enthusiasm, commitment and prioritisation.

**6.2.** Smoking cessation and ‘core’ work

**6.3.** Dedicated staff and service sustainability

**6.4.** Role of different health professions.

**6.5.** Chapter Summary

#### **6.1. Enthusiasm, commitment and prioritisation**

Involvement in smoking cessation service provision, and service co-ordination/management (in three LHCCs in particular), was commonly perceived to be underpinned by personal and/or professional interest in smoking cessation, and the priority assigned to smoking cessation as a professional duty.

As outlined in chapter four, a range of professionals undertook the management/co-ordination of local smoking cessation services. When the co-ordinating role was undertaken by Development Managers/Public Health Practitioners, interviewees were less likely to discuss the enthusiasm and commitment of such staff in

facilitating local service development. This might be explained by the fact that a 'co-ordinating role' may have been perceived as falling within the traditional remit of such professions anyway. However, the involvement of 'non-traditional' professions in these management/co-ordinating roles (i.e. health visiting; pharmacy; nursing) was commonly perceived to be underpinned by personal enthusiasm and commitment towards smoking cessation.

Within LHCC 'F', it was a health visitor who had a prominent role in service development and delivery from an early stage. Prior to the publication of *Smoking Kills*, this health visitor had a strong professional interest in smoking cessation. Consequently, when *Smoking Kills* funding became available, s/he was approached by LHCC management to provide key smoking cessation support. S/he was also involved at a strategic level in the development of local services. As this health visitor co-ordinated the referrals for group support throughout the LHCC, s/he was viewed by staff within the LHCC as the local co-ordinator. The following quote is from an interviewee within this LHCC. Clearly, enthusiasm for smoking cessation was perceived to underpin this health visitor's involvement in service development/delivery:

**Int:** So are there any other key problems in the development stage that you might not have mentioned yet, or even key facilitating factors as well, like any key positive influences that you thought...at that stage...

**R2F:** Em...I think we had a very positive influence in that we had one or two people, and as I say [name: LHCC smoking cessation co-ordinator] in particular, who were extremely motivated and interested in smoking cessation, from the staff point of view. But there were very positive staff, and there were also negative ones. But that was positive. **(LHCC Management/Strategy/Co-ordination)**

Within LHCC 'D', the primary care pharmacist had undertaken the role as smoking cessation co-ordinator. This person had been proactive in seeking this role. Specifically, s/he had become aware of the *Smoking Kills* funding, and was keen for pharmacy to develop a smoking cessation role. The following quotation is from a health professional within this LHCC, who was commenting upon the factors

facilitating local service development. Enthusiasm from the smoking cessation co-ordinator was deemed by this respondent to be key factor in service development:

**R2D:** Well...I think whoever's organising it, they've got to be enthusiastic, and we were lucky that [name: LHCC co-ordinator] was enthusiastic. **(Service delivery)**

In addition to the staff in a co-ordinating role, the 'on-the-ground' staff who provided the intensive smoking cessation support, were often perceived by LHCC respondents to provide the 'backbone' to local smoking cessation service development. Firstly, commitment from one or more health care professionals in providing intensive smoking cessation support was commonly perceived to enable services to initially get up-and-running. Additionally, this commitment was perceived to provide an impetus for continued development and expansion. For instance, respondent R1B commented on the crucial role of key health visitors within the LHCC. These health visitors provided smoking cessation support, and had a strong personal and professional interest in smoking cessation. Consequently, they were described as keen to establish smoking cessation services within the LHCC:

**R1B:** We will do the very best we can with what funding we've got, but we've always found...I have always found it a bit of a poisoned chalice- when it hit my desk I thought 'this is just ludicrous, it's a no-win situation', and if it hadn't been for the goodwill, the interest, and involvement of two or three health visitors, this would never have got off the ground. **(LHCC Management/Strategy/Co-ordination)**

Respondent R1B went on to say:

**R1B:** If it hadn't been for them, if it wasn't for them, this wouldn't be happening. **(LHCC Management/Strategy/Co-ordination)**

Those staff 'on-the-ground' were often perceived by LHCC respondents as being the key link between the smoking cessation service as a 'concept' and it being rolled out in practice. This specifically occurred through the provision of support in running and organising smoking cessation groups, and in dealing with the 'on-the-ground' practicalities. In the following data extract, respondent R1D reflects upon the early

stages of local service development, and the key role that enthusiastic staff played in advancing service development:

**Int:** Initially, how easy was it to get staff involved?

**R1D:** Em...we didn't have any problems at all, actually. Em, it's one thing that, I know from speaking to other colleagues in other areas, we've been quite fortunate because we've got some real enthusiasts here, and they're just completely driven and they'll finish one group- 'when can we start another one?'. And you know, you speak to other areas, and they can't get anybody to do anything and, you know, it's not a problem we've ever had. **(LHCC Management/Strategy/Co-ordination)**

R1D went on to describe the enthusiasm amongst these staff, and their willingness to provide the smoking cessation support:

**R1D:** And you know, again, it's a case of as soon as they've just about finished one, they'll phone and they'll say 'right, let's get the next one in'. And I know we're very fortunate with that. Em, that they just happened to be into smoking cessation. So we've not had any problems. **(LHCC Management/Strategy/Co-ordination)**

In the first extract, interviewee R1D above compares the LHCC with the situation in other areas. Clearly it was perceived that staff enthusiasm within this particular LHCC surpassed that in other areas. The responsibility for service development in this LHCC was undertaken by a lead pharmacist. In the early stages, it was principally a few pharmacists who were involved in providing the intensive group support in LHCC 'D'. It is possible that having a pharmacist leading local service development was a precipitating factor in staff (pharmacist) involvement. However, interviewee R1D, below, clearly perceived staff *interest* to be the key factor.

**R1D:** We've been very lucky. I don't think we'd have had such a success if we didn't have all those kind staff on board.

R1D then went on to add:

**R1D:** It's just obviously something that they're obviously interested in themselves. So long may that continue, actually, because it has been the kind of the secret of the success, 'cos they do kind of give it a wee bit extra every time. But it's never been a problem. **(LHCC Management/Strategy/Co-ordination)**



Intensive smoking cessation support (groups/one-to-one) was not provided by all staff within the LHCCs. There were often 'pockets' of activity and inactivity within LHCCs. Many interviewees reflected upon the commitment that was displayed by those staff who *did* provide this intensive support, and the identification of smoking cessation as a clinical priority was perceived to be a key factor in facilitating local service delivery. For instance, one interviewee in an LHCC that opted for a practice-based approach, reflected upon her/his professional background in community nursing and primary care. S/he suggested that, from her/his professional experience, adoption of an issue such as smoking cessation would largely depend on it being prioritised by staff locally. Subsequently, relying on staff interest was perceived by this respondent as contributing to disparities in local service delivery:

**Int:** I'm also interested to see why some Practices have developed, and others haven't- was it really down to the interest of staff who wanted to take it forward?

**RIA:** Em, I mean...I'm guessing, because I wasn't around at that particular time, but I've come from a primary care background, and a community nursing background but...yeah, that would be my guess, that there would be a health visitor, or a practice nurse, or a - or somebody, or possibly two or three of them who thought 'you know, this is...we should really get into this', and has taken on the kind of responsibility locally for ensuring that it happens, including putting in the time to either run a group or do one-to-one, or to try and say 'look we can do this, but frankly we're going to need five hundred quid or a thousand pounds to do it', and undertaken to try and find that money, apply for the money, whatever. **(LHCC Management/Strategy/Co-ordination)**

Respondent R1A went on to discuss possible explanations as to why some health professionals prioritised smoking cessation, whilst others did not. Personal and professional (clinical) interest were identified as two key factors:

**RIA:** Em, and in other areas it's just been, you know, people have been going 'smoking cessation -sorry, I'm just not, you know, I personally, I'm not interested....you know, from a clinical perspective it's not an area that I want to spend time on and develop, and I've got far too many other things to do'. **(LHCC Management/Strategy/Co-ordination)**

The latter extracts (respondent R1A) highlight the variations that could take place across GP Practices within an LHCC. This was re-iterated by many interviewees. A lack of staff involvement in the provision of smoking cessation support was often attributed by respondents to a lack of personal and/or professional interest from those not involved. However, as the following extract also indicates, this variation in interest and prioritisation was not perceived to be an issue particular to smoking cessation, but to health promotion issues more generally:

**Int:** so it sounds like the interest of staff was one of the key ones [factors involved in service development]...

**R3A:** yeah, I think so, and I think you can probably apply that to lots of areas of health promotion actually. You get much more done if you're taking people [few words?], capitalising on enthusiasm that's there. It's never particularly effective if people who don't want to do it are told that they have to. You're going to get a lot of problems with that actually, because what do you do with the areas and Practices where there isn't any enthusiasm...and where the patients are going to lose out. (**Service Delivery**)

The above extract makes reference to wider health promotion activity, beyond smoking cessation. It raises the question of how smoking cessation, and health promotion more generally, falls within health professionals' core work. This issue, however, will be discussed in more depth in section 6.2. of this chapter.

In one LHCC that opted for a practice-based approach, there was a degree of uncertainty around the precise nature and extent of smoking cessation support that was being carried out within the practices in the LHCC. As was discussed in chapter five (Service Development and LHCC Capacity), the variability in smoking cessation support provided by local GP Practices in LHCC 'A' was largely attributed, by respondents, to a lack of central co-ordination of the services within the LHCC. A health professional from LHCC 'A' reflected on the lack of priority that assigned to smoking cessation within her/his practice. Respondent R2A reiterated a 'reliance' on those who had a personal interest in smoking cessation for service delivery sustainability:

**Int:** Do you think em- because one thing I'm interested in looking at is the sustainability of the services- do you think, obviously

you're interested in running the groups and things, but do you think that's a key part, the interest of staff?

**R2A:** Oh, without a doubt, because I think em the way it's run at the moment, that...that they are, they're running it in their own time....as far as I know. From the people that I've met, I think they run it in their own time- I don't know whether they get their time back or not, but, you know, I think certainly the way things have progressed here [within the interviewee's own Practice], it's em very much 'well the money's not here, well we're not prepared to put the effort in for it'...because they don't value it enough. So I think it is, I think it's down to people who have a special interest in it. **(Service Delivery)**

The above extract suggests that within the interviewee's own practice, there was a general lack of priority assigned to smoking cessation. The interviewee went on to discuss a lack of support from the practice GPs in developing a smoking cessation service within the practice. The extract indicates that financial issues were a factor in this (the issue of funding will be discussed thoroughly in chapter seven), but also suggests that smoking cessation was not a 'valued' service. With regard to the latter issue, this particular LHCC lacked central co-ordination and direction for the development of smoking cessation services. This may have contributed to the perceived unimportance of smoking cessation amongst LHCC staff. What is clear from this extract above however is that the individual prioritisation of smoking cessation by individual staff members was perceived to be a key factor underpinning service delivery.

Personal interest in, and prioritisation of, smoking cessation was therefore described by many respondents as a motivating force in encouraging staff to become involved in delivering intensive smoking cessation support. One of the outcomes of this dependence on staff interest and enthusiasm, however, was that services were often perceived to be shouldered by a relatively small number staff and/or focussed in one health profession in particular (e.g. health visitors):

**Int:** From something you said earlier, it sounds like the Health Visitors who are providing support....is it largely down to individual interest and motivation....?

**R2B:** yes. The ones who are doing it are the ones who have an interest in it. And also some of them like doing group work, and

you know, it's maybe the one opportunity they have to do group work, so that's why people are doing...but hardly...I mean to be honest, I don't know how many have done a group this year- maybe two of them have done a group this year, out of...what, 45 health visitors! So...yeah, they're not hugely motivated to do it, I have to say. (LHCC Management/Strategy/Co-ordination)

One consequence of the provision of smoking cessation support that relied on personal interest and a limited number of staff, was that smoking cessation could encroach upon staffs' personal time. Consequently, smoking cessation could become a much more significant part of their core work compared to the counterparts of those providing intensive smoking cessation support. Quite often, therefore, staff involved in smoking cessation service delivery were perceived by respondents to be providing smoking cessation support on a 'goodwill' basis. This issue will be discussed in the following section around smoking cessation and 'core' work.

## 6.2. Smoking cessation and 'core' work

Thorax guidelines (Raw *et al.*, 1998a) and the Smoking Cessation Guidelines for Scotland (HEBS and ASH Scotland, 2000), recommended that smoking cessation activity be a core activity within primary care. The following is an extract from the Thorax guidelines, which the Scottish guidelines re-iterated:

*"It is essential that smoking cessation- identifying smokers and intervening with them- be made a **core health care activity**, and this means that funds will have to be found, perhaps diverted from ineffective or less cost effective treatments"* (Raw *et al.*, 1998a, p.16- emphasis added)

### 6.2.1. Demands on staff time

It was common for interviewees to refer to smoking cessation work being carried out on a 'goodwill' basis, given that smoking cessation was not perceived to be a part of health professionals' 'core' work. By 'goodwill', health professionals were perceived by respondents to be 'fitting it in' around their core work duties. As the following data extracts indicate, smoking cessation was perceived as an 'extra' activity that was *accommodated* within health professionals' daily duties:

**Int:** Do you think most staff who provide smoking cessation support see it as part of their core work?

**R3B:** no, they see it as an extra, but they give it core time. They see it as something that they're doing from goodwill- that they're having to manage the rest of their work to allow them that time. **(Service Delivery)**

**R2I:** Any of these health professionals have a long list of essential tasks they have to do, and probably it doesn't fit anywhere at the moment as somebody's essential task, within their job description. Em... 'cos it's different disciplines...you know, pharmacists, health visitors, district nurses, practice nurses, they're all quite...varied, they've got different responsibilities, and so it probably isn't anywhere in anybody's fundamental job description, that they have got to do this. So at the moment, it's done out of people's enthusiasm and goodwill. **(Advisory Group)**

Respondent R2I, above, highlighted that smoking cessation was not regarded as an "essential task", given that it was not incorporated within health professionals' core job descriptions. It was commonly perceived by interviewees that the responsibility for developing the services had been placed upon the LHCCs without the funding and additional support to help follow it through into practice (i.e. to cover staff time and additional resources). One area of contention was the perceived increasing demands being made on staff within primary care:

**R2I:** And I suppose you need to say why it [smoking cessation service development] was rocky, why was it...you know, for something that was a positive new thing, it's a shame that it was...it had a rocky beginning, and resentments were there. But I suppose the basic resentment- 'cos I'm seeing it from both sides, so to speak, from the [health profession] side is, where you're in a climate where more and more things are being asked of Primary Care, and the usual thing is we're being asked to do more and more things without the resourcing to free up people, and you know, the practice nurse is fully employed being a practice nurse- she hasn't necessarily got the time to do...other things. **(Advisory Group)**

Respondent R2I above posited that it was difficult for primary care to absorb the additional workload required to deliver smoking cessation services. In the data extract below, respondent R2B discusses the issue of 'core' work. It appears from this data extract that there was perceived to be conflict between what health

professionals (particularly health visitors) perceived as their “core” work, and new demands being placed on their workloads:

**R2B:** But I do think the idea that we’re expecting mainly health visitors to do it on top of a very busy workload, and it seems to me health visitors are asked to do loads of things, on top of- they’ve got core work they’re supposed to do, and over the last two or three years there’s just been...’and will you do this, and will you do that, and will you do this’. I mean you can’t do that to people, because in the end they’re going to say ‘well no actually, we’re not doing it’. And I think that’s what they’re doing with smoking cessation quite a lot. So that’s a problem. **(LHCC Management/Strategy/Co-ordination)**

Smoking cessation was therefore perceived by many respondents as something that was difficult to incorporate into ‘core’ working practice. This difficulty was attributed by respondents to the full workloads of staff within primary care, and the increasing, and competing, demands on staff time.

### **6.2.2. Smoking cessation, ‘core’ work and health professionals**

There appeared to be three different perceptions about how smoking cessation fitted within a health professional’s ‘core work’ remit. I will go on to discuss each of these in turn:

- 6.2.2.1. Enthusiasm for smoking cessation but it was essentially viewed as an ‘add-on’ service.
- 6.2.2.2. Smoking cessation was perceived as an ‘add-on’ service, but ‘core’ to a health professional’s personal priorities/agenda.
- 6.2.2.3. Smoking cessation was perceived as fundamentally ‘core’ to the duties of the health professional.

#### ***6.2.2.1. Enthusiasm for smoking cessation, but essentially an add-on service.***

Section 1 of this chapter outlined how personal priorities and commitment to smoking cessation were perceived to underpin involvement in smoking cessation. However, as I will now go on to discuss, this enthusiasm did not necessarily equate to smoking cessation becoming a *core* part of a health professional’s remit. As



respondent R1E below intimated, smoking cessation rested on staff interest, but was not necessarily perceived to be a core part of health professionals' job descriptions:

**Int:** I'm not sure if you would know, but what's the general attitude of staff towards providing smoking cessation...do they see it as a priority?

**R1E:** I think people....some of them do- some of them enjoy actually providing the service, others would be happier...probably don't necessarily see it as part of their core working –especially for Health Visitors, em...they're time could be better spent on something else. **(LHCC Management/Strategy/Co-ordination)**

This particular LHCC had opted for a practice-based approach to smoking cessation, and smoking cessation support (predominantly one-to-one) was offered within each practice. This support was offered by one member of staff, who had opted to undertake a smoking cessation role. However, the data extract above suggests that smoking cessation was not perceived by respondent R1E to be something that had become fundamentally core to the work of these health professionals. R1E proposed that staff may perceive that their time could be “better spent on something else”, suggesting that smoking cessation was not perceived by such staff to be a core priority. R1E went on to discuss that staff delivering smoking cessation support could possibly relinquish their smoking cessation role:

**R1E:** There have been difficulties in other areas, of actually trying to get someone employed, or trying to get staff to do it, because they're just so busy with other work. So I think, that yes, they'd probably give it up tomorrow if there was someone to provide it, but they're quite happy to continue it just now. **(LHCC Management/Strategy/Co-ordination)**

In the following data extract, respondent R1F discusses the difficulties experienced in recruiting staff to provide smoking cessation support within her/his LHCC. At the time of conducting this interview, there were reported problems in recruiting staff to run evening groups. In the following extract, R1F appears to attribute this difficulty in staff recruitment to (a) increasing demands on staff time, and (b) waning enthusiasm amongst such staff for providing smoking cessation support:



**R1F:** It's [smoking cessation] supposed to be core work, but I think to begin with staff were enthusiastic, and we just lost it, because it's just gone on and on and on...and more and more bits keep being added to the core work. So it's like an overflowing bath- just too much core work, and we haven't got enough time.  
(LHCC Management/Strategy/Co-ordination)

This section has discussed instances where health professionals were perceived to be initially enthusiastic about smoking cessation work, but had not incorporated it into their core working practice. Respondents appeared to attribute the difficulty in incorporating smoking cessation into health professionals' core work, to increasing and competing demands on staff time. This perhaps suggests that health professionals may have wanted smoking cessation to be a core activity, but that such demands on their time may have rendered it difficult to do so.

#### ***6.2.2.2. An 'add-on' service, but core to the health professional's personal remit***

This section expands upon the concept of 'enthusiasm' introduced in section 6.2.2.1. to incorporate discussion around smoking cessation as a 'core' personal agenda/priority for health professionals. There were staff who appeared to describe smoking cessation more as an 'add-on' activity. However, at the same time, it was clear that it in many cases, smoking cessation was perceived to be an activity that was 'core' to them personally.

In the data extract below, one health professional describes how smoking cessation was perceived as an additional part of the workload. However, reference to undertaking smoking cessation support because "*it's going to make a difference*", suggests that helping smokers quit was core to this health professional's personal agenda:

**Int:** you mentioned earlier about the core...I mean how smoking cessation is maybe not seen as part of core work. Is it the same across the board with people providing support within this LHCC. I mean how much is it seen as an additional part of the workload?

**R3C:** Everybody except for the people who are actually employed to do the job- for everybody else who's already in post, it's just one more thing that needs pegging on to do. And you then take on something like that if you feel you can do it, and it's going to make

a difference. I suppose if I get one person to give up smoking for the rest of their lives, I feel I've succeeded in doing something, so there's a certain amount of self, you know, satisfaction, in hearing that three-months down the line we've got, you know, 52% or something [success rate]. **(Service Delivery)**

Although respondent R3C, above, did not appear to perceive smoking cessation as a core part of her work, she described personal satisfaction in helping smokers quit. In many cases, smoking cessation support was not carried out by health professionals as a 'core' working day activity, and health professionals ran smoking cessation groups at night. Alternatively, health professionals could be paid to attach additional hours onto their day for service provision, especially if they worked part-time and wanted to provide support. Smoking cessation was therefore often considered an additional activity, but was still a personal priority for the health professional involved. For instance, another health professional talked with enthusiasm about the impact of smoking on health, particularly within the context of his/her professional background in working with neonates:

**R4D:** I'm a non-smoker, and I have a real interest in health, sort of physical health. I'm interested in anatomy and physiology, and I started in neonates, where I watched health develop with the pre-term. And now what I'm seeing with the smoker is health deteriorating, so it's the complete opposite end- it's being removed. And with the neonate I saw the biggest problem being with the lungs, development of the lungs, and how when you improve ventilation things improve. And now I've got the smoker the opposite way round. Probably in terms of the non-smoker, with the fact that these people are willingly taking this on-board, makes me want to inform them of all the different issues. **(Service Delivery)**

Respondent R4D, therefore, described personal and professional motivation to help smokers quit. However, as the following extract demonstrates, smoking cessation was still perceived to be *additional* to his/her core duties as a district nurse. S/he attributed this to the fact that smoking cessation work was not part of his/her remit:

**R4D:** I have to say it's [smoking cessation] an add-on for me, em...and the reason I say that is because it's been added onto my career, my experience, and my role as a nurse [...]. Em yeah, so it's an add-on.

Int: so were you given extra time to make this part of your work then?

R4D: what happens is that I get an hour...at the end, for my group work, em, so that's been recognised. And it was something I shouted for, so I think it's come through the planning process, that eh...you know, this is...it's about commitment.

Respondent R4D went on to add:

**R4D:** So I would say this would be one as extra, and paid as extra, because this is an add-on to the service I provide, and that way I think, you know, it's reimbursement for commitment. (**Service Delivery**)

Clearly, R4D perceived smoking cessation to be an add-on activity, and not a traditional part of his/her "*role as a nurse*". It is unlikely that 'core' work activities would be discussed in the context of "*reimbursement for commitment*", thus indicating that smoking cessation activity was perceived by R4D to rely on personal commitment and enthusiasm, and was not perceived to be a 'core' work activity.

It was clear, however, that in some cases, staff had incorporated smoking cessation into core working practice. In such cases, it appeared from respondents' accounts that smoking had been identified as a core task, and had been integrated into working practice as such. This leads on to the discussion around smoking cessation as a core part of health professionals' remit.

#### **6.2.2.3. Smoking cessation as a core part of a health professional's remit**

Several health professionals discussed how they had incorporated smoking cessation into their 'core' working practice. For instance, in the following data extract, one health professional describes how s/he assigned *core hours* within her week to provide smoking cessation support within her/his GP Practice:

**Int:** I'm also interested in finding out how people, like yourself, who are delivering the service- how much do you see it as part of your core work, and how much is it seen as an additional workload.

**R3B:** I try and keep it core in that I try and have a Monday afternoon slot in my diary [...] So I've tried to develop a structure. Although I've just changed offices, I've got two colleagues on holiday, Christmas is coming up, and I've just not got my new lot

organised. But, I've got this week to sort for January. So, it is difficult, you know. It's something...you have to be quite confident of your work...to keep it as a priority. **(Service Delivery)**

R3B argued, therefore, that it required a conscious effort to keep smoking cessation as a priority within the caseload. S/he also suggested that it was not easy to incorporate smoking cessation into the core, day-to-day workload. Maintaining the profile of smoking cessation as a priority and core service, however, appeared to be important to several staff. The following data extract describes the situation in one Practice whereby smoking cessation work had been prioritised by members of staff. As the data extract highlights, it was proposed by R5A that even in the absence of funding, smoking cessation would remain a priority:

**Int:** I suppose the kind of final issue is your impressions of the sustainability of the service, maybe generally, over the coming year, and any issues you think are...?

**R5A:** Em...things were a little bit- we did worry a little bit because we did think that we weren't going to get any funding, you know, there was this huge issue when the year came to an end...people in high places were saying 'you're not going to get any funding, you know, there's not going to be any more funding for smoking cessation'. But we discussed it, and really there are enough of us that are keen enough to continue without getting paid for doing it, and just to carry on taking our time back. **(Service Delivery)**

This respondent went on to add:

**R5A:** And we're quite happy to continue doing the classes, so I think we'll sustain it for as long as we possibly can, you know, it doesn't- as I said, it's part of our core work now, so I don't see us not doing it. **(Service Delivery)**

R5A therefore posited that smoking cessation had become "core work" for those staff involved in providing support within the Practice. This interviewee worked in a Practice where there appeared to be a positive culture around smoking cessation. It was one of the few practice areas within the LHCC that had developed a comprehensive smoking cessation service. Clearly smoking cessation had come to be perceived as a core part of health professionals' work, and was described as an activity that would remain a priority within the practice.

Evidently, there were health professionals who regarded smoking cessation as a priority, had integrated the provision of support into their day-to-day work, and perceived it to be a core part of their remit:

**RID:** The real kind of activists about it, that see it as really core to their work, are the ones that are running the groups, and that's why they're still running the groups. (LHCC Management/Strategy/Co-ordination)

With regards to the issue of 'core' work, therefore, those health professionals providing smoking cessation support perceived smoking cessation in three distinct ways. It was apparent that, where smoking cessation was not perceived to be a 'core' part of health professionals' core work, this was perceived by respondents to have implications for the sustainability of local services. This issue of service sustainability is discussed further in the following section.

### **6. 3. Dedicated staff and service sustainability**

There was a general sentiment amongst interviewees that reliance on staff 'goodwill' and/or enthusiasm was not a suitable long-term option for the sustainability of local services. Due in part to these concerns, respondents argued that dedicated staff should be specifically employed to carry out smoking cessation duties. It was argued by respondents that dedicated personnel would alleviate the pressure on those staff shouldering the responsibility for service delivery. It was also suggested that dedicated staff would ensure the sustainability of the services when current staff moved on:

**R3A:** It's dependent on staff locally being keen and enthusiastic, so all you need is for somebody to move jobs, and...it could maybe fold. (LHCC Management/Strategy/Co-ordination)

**Int:** It seems like it's [smoking cessation] falling on quite a small number of staff...

**R1C:** I think you'll find...well that's why we need people that have time, just dedicated to this. I think you'll find in other LHCCs, even where people trained, um....that they'll do it for once or twice, but it is difficult for them to maintain it, and there are

problems with sustainability over that. **(LHCC Management/Strategy/Co-ordination)**

Respondent R1C went on to discuss in more detail the difficulty associated with relying on the 'goodwill/enthusiasm' of staff. As the data extract below suggests, the problem of service provision more complicated than simply paying staff to provide smoking cessation support beyond their core working hours. Instead, smoking cessation support was perceived to rely heavily on staff being *willing* to carry out this extra work:

**R1C:** The trouble is, if these women [Health Visitors] are starting at 8am in the morning, or 8.30am what have you, they don't want to stay around until 6.30, run the groups until 7.30/8pm. They do it, I mean we've got people who are doing it, but it is a pressure on them. And you're also finding them saying 'I've run 3 lots of this group back to back, this is taking over my life, I don't want to do it anymore'. So even people that have been willing to do it for a while, will do it for a couple of times then say 'sorry, I've got a life, I've got a family, what are you doing here'. So even if I have money to pay people extra hours, it's an issue, you know, who's going to do this? **(LHCC Management/Strategy/Co-ordination)**

It was clearly perceived by many respondents that relying on the goodwill of a select number of staff was not a viable route for ensuring service sustainability. Although it was clear that several staff were fully committed to smoking cessation, and would likely continue to provide a service on a goodwill basis, respondents expressed strong concerns that local services could not continue to be delivered on such grounds. In the following data extract, respondent R2I attributes the need for dedicated staff to (a) the lack of a stable workforce in primary care, and (b) smoking cessation not being a core part of health professionals' work:

**R2I:** Yes, because if people move...people move, and there's a huge movement of staff within primary care. Em, so you know, at any given time there'll be a group of people who've been trained or enthusiastic, but as soon as they've moved [few words?] and...you know, if their replacements haven't had the training, it wouldn't be identified as a core requirement for them, that they should have smoking cessation training, you know. It may happen if they request it, em...so you know, you have to sort of look at these things being built into people's core job description, and I suppose



that probably isn't there in anybody's, at the moment. Em, so that's why the ideal thing would be to get a dedicated person, but designated people are expensive. (**Advisory Group**)

Interestingly R2I talked about being able to give dedicated staff 'objectives' with regard to smoking cessation service delivery, reiterating the perceived difficulties in developing a fully comprehensive and 'formal' service when it was not perceived to be part of staffs' core workload.

Several interviewees reflected on the fact that the funding was insufficient for the employment of dedicated staff members to provide smoking cessation support on a formal basis, as respondent R1F discussed:

**R1F:** I just don't think there's enough money to do anything useful with. Getting a few thousand a year is not enough. If there was enough to pay someone a salary to do it full-time, yeah, then you'd get something done. But £6,000 is a drop in the ocean, it can't even pay for people to come out in the evening or anything-like pay for two sessions a week or something- just nothing.

**Int:** So you can't really do much with it?

**R1F:** No. Maybe if they put in something like £25,000 to pay someone to do it, yeah, it would be quite important I think.

(**LHCC Management/Strategy/Co-ordination**)

Although interviewee R1F argued that funding was insufficient to employ a dedicated staff member for providing intensive smoking cessation support, two LHCCs employed a dedicated smoking cessation nurse (one nurse who worked between the two LHCCs), to deliver smoking cessation support. Respondents from these LHCCs discussed that Health Improvement Fund (HIF) money was used to employ this nurse. It was posited by respondents from these LHCCs, that having a dedicated resource was important for offering service continuity. The dedicated smoking cessation nurse was employed by these LHCCs to supplement existing services where there were considered to be specific weaknesses in service provision (e.g. carrying out the motivational interviews; doing the smoking cessation groups at regular intervals to offer a continuous service). However, as outlined by respondent R1F above, the funding that was allocated to the LHCCs was not considered by LHCC respondents to be sufficient to employ a dedicated staff member on a full-time



basis. The two LHCCs that did employ the smoking cessation nurse only did so for one/two days per week.

One of the ways in which gaps in service delivery could be addressed at the local level, was through the employment of Health Promotion Assistants (HPAs). These were 'floating' staff employed by the Health Board, who could undertake a range of health promotion tasks within the LHCCs. They were essentially viewed as 'dedicated staff', in the sense that they looked upon as a dedicated resource that could be tapped into. However, in practice, there was uncertainty around relying on HPAs for service provision in the longer-term. Specifically, it was proposed that HPAs did not really meet the criteria of being 'dedicated' and 'committed' staff, and therefore did not entirely offer the continuity of service provision that was required. Respondents discussed that HPAs were essentially a 'mobile' population of workers that would move onto other jobs quite quickly, in addition to not always being readily available for smoking cessation work when required. Consequently, HPAs did not appear to feature prominently in service provision within the LHCCs.

Many interviewees, therefore, posited that dedicated workers should be employed to support existing services, and provide stability for services in the longer-term. However, a few interviewees argued that using dedicated staff to support service delivery was not the best method for long term service sustainability, and that smoking cessation should essentially be incorporated into health professionals' core workload:

**R1H:** If health visitors and practice nurses don't do anything in smoking cessation, and say 'oh go and see so and so- that's the person who does smoking cessation', it's going to be seen by patients as 'oh, it's acceptable to smoke'. Whereas if everybody- GPs, practice nurses, health visitors, and so on, all give the message that...you know...trying to help someone to stop, that's what works- even if it's through a brief intervention, or whatever. That is what works- not to put it as 'oh, there's somebody who deals with somebody who wants to stop smoking', and 'we don't need to deal with it'. **(Health Board)**

Interviewee R1H went on to discuss LHCC 'G' that provided smoking cessation support prior to the publication of *Smoking Kills*. R1H posited that the experiences of this LHCC suggested that one dedicated worker providing smoking cessation support provider was not an efficient form of service delivery:

**R1H:** They [LHCC 'G'] had one person working on smoking cessation, before all the health visitors started up, and that certainly was not enough. They needed to get all these other people doing it as well, and it does need to be part of the workload. But LHCCs seem to have this idea that the money should come from the Health Board, be spent on that, and they don't need to do anything else. And it's not about that, they need everybody doing a bit of smoking cessation. It should be part of everyone's remit. **(Health Board)**

As discussed previously, interviewees reflected upon the difficulties involved in incorporating smoking cessation within core work, given demanding workloads, and a perceived lack of funding/resources to do so. However, one interviewee posited that some form of compromise was required. Specifically, respondent R1A below argued that instead of relying solely on funding from the Health Board/Scottish Executive to develop a specialised smoking cessation service, primary care should accommodate the smoking cessation service within core work duties:

**R1A:** It has to be incorporated into core work. We have to find a way for it to become- I mean whether that needs a lot of money to kind of start it off. I don't think we need to find the amount of money to cover every single hour, or every single person's activity. But there are health visitors and district nurses and practice nurses, and others, who are quite happy to do this amount of work, and have found the time to do it. **(LHCC Management/Strategy/Co-ordination)**

This respondent later went on to say:

**R1A:** There needs...I think the sustainability- and element of it needs to continue as people just accepting it as part of their core work, and they need to find space in their working day to support some of this, and that's a perfectly legitimate thing to ask of primary care. **(LHCC Management/Strategy/Co-ordination)**

R1A, therefore, posited that dedicated staff was not a viable long term sustainable option, and that there was a need for staff to incorporate smoking cessation into core working practice. There was the acceptance that this was a “legitimate” expectation of primary care. However, at the same time it was argued by R1A that some kind of compromise was required, and that the Health Board should provide a sufficient amount of funding to facilitate this. From what was discussed previously in this section, however, it is clear that the level of funding allocated for the development of services was not perceived by respondents to be sufficient to allow for this.

### **6.3.1. Training**

Several interviewees argued that in order for smoking cessation to be incorporated effectively into core working practice within primary care, it was important that as many staff as possible were trained in providing support. The movement of staff within primary care (i.e. depletion of local skill-bases) was discussed previously as a factor that was perceived by respondents to impact upon local service sustainability. However, in the following data extracts, respondent R2E and R3I discuss how training could ensure that smoking cessation became a ‘core’ part of all health professionals’ work:

**R2E:** I think if, em, because more people are being trained that [smoking cessation support provision] should be sustainable, and, em, hopefully will be integrated into everybody’s work.

**Int:** As a core part of work?

**R2E:** Yes

**Int:** Do you not think that is the case at the moment?

**R2E:** Eh, uh-huhh. Well I think it is and I hope, well, maybe not- if everybody can advise people and help people to stop smoking, them, em, the load will be shared, and there won’t be the need for extra time to do it. **(Service Delivery)**

**R3I:** For two years you would actually smother the market with em, you know, skills and knowledge to enable people to take forward the work. Then you’d just provide sort of top-up courses, or specifically targeted ones if there was a request. So that comes to be core business. **(Health Board)**

Training was therefore perceived by some respondents to be an integral part of ensuring service sustainability. That is, it was proposed that the training of as many

health professionals as possible would facilitate the integration of smoking cessation into 'core' working practice.

#### **6.4. Role of different health professions**

*Thorax* guidelines (Raw *et al.*, 1998a), and the smoking cessation guidelines for Scotland (HEBS and ASH Scotland, 2000), recommended that a range of different health professions should be involved in the delivery of the smoking cessation services. Those health professionals making first contact with patients would provide brief interventions. In most cases this would be GPs, but would include other health professions such as midwives or pharmacists. Likewise, a range of different health professionals would provide the intensive smoking cessation support. In particular, this would involve those most suited to doing so, in terms of being able to accommodate intensive smoking cessation activity within their work.

Within the Health Board under study, it was the norm for the intensive smoking cessation support in the LHCCs to be provided predominantly by health visitors, practice nurses, and other nursing professions (district nurses; primary care nurses). In two LHCCs however, there was also a strong pharmacy input, whereby groups/one-to-one were provided by pharmacists within their premises. As outlined above, the brief interventions could be provided by a range of health professionals, but it was mainly General Practitioners who were regarded as being the first point of contact for patients, and having the responsibility for referring patients on for intensive support when required. The role of GPs in service delivery was therefore central. However, there were perceived variations in enthusiasm for, and attitudes towards smoking cessation within this profession, which will now be discussed.

##### **6.4.1. The role of GPs**

There were a few GPs actively involved in the early stages of service development across a couple of the LHCCs, as well as a GP representative on the Health Board's Tobacco White Paper Advisory Group. There was, therefore, an apparent enthusiasm from some GPs for their profession to be actively involved in implementing the smoking cessation strategy. However, this was not necessarily the

case across the board. Many interviewees' perceptions were that GPs did not consider smoking cessation as an activity that they should get involved in. This is demonstrated by one health professional's experience of trying to initiate training for General Practitioners in smoking cessation:

**R2I:** When the Tobacco White Paper came out, and this money came out, we decided to run a course...you know you get health promotion courses at the [organisation name], one or two a year, and we decided to run one on smoking, because the *Thorax* guidelines had just been published, and it was seen to be quite a hot topic- and with the announcement of this money. So we planned a course, and it had to be cancelled, as it was just specifically for GPs, and there was complete lack of interest in coming along. And that was at a time, you know, there were editorials in the BMJ, it was the start of the discussion about how this could be done in primary care. **(Advisory Group)**

The above interviewee then went on to describe why GPs may have lacked interest in smoking cessation, suggesting a reluctance to be involved in activity other than prescribing:

**R2I:** Certainly having spoken to some GPs when this [smoking cessation service development] started, they felt this was something they didn't want to be involved in at all. They were quite happy to write a prescription, but that was it. They were not wanting to take on this work. **(Advisory Group)**

The following data extract suggests little perceived enthusiasm for embarking upon smoking cessation training amongst this profession. In the early stages of service development there were training courses in smoking cessation widely available for health professionals. It tended to be health visitors and nurses who undertook this training. Respondent R2I cited below, however, argued that GPs would also benefit from smoking cessation training:

**R2I:** I tried to- this is slightly on a tangent- I tried to...em evaluate whether there was a need within the LHCCs for GP-specific training on smoking cessation, because I knew that the courses that were being offered were mainly being offered to nurses and health visitors, and I felt that the doctors themselves hadn't had much opportunity to have training. So I em...with...[name] looked at doing a two-hour over lunchtime, sort of short session, and wrote to

the LHCC General Managers to see if there was any interest. And in two of the areas there was interest, but in all the others the answer was no- 'doctors are not interested in it'. (**Advisory Group**)

Respondent R2I went on to discuss benefits of training GPs in brief intervention, which reflected the expressed sentiment of several interviewees. It was widely posited by respondents that the GP's role in providing smoking cessation support was traditionally passive and inconsequential. Specifically, it was argued that patient motivation was not generally adequately assessed by GPs. Respondents also suggested that the approach typically taken by GPs to tackling lifestyle issues such as smoking was not congruent with the motivational approach underpinning the ethos of the new smoking cessation services. As the first extract below indicates, GPs' traditional approach to tackling lifestyle issues was characterised as an expert-led and top-down approach. As demonstrated by the following extracts, many respondents suggested that brief intervention training could help GPs to deal with patients in a more pro-active manner. This, it was argued, would be beneficial in helping patients to stop smoking. Also, given that smoking is an issue that GPs deal with on a regular basis with patients, it was perceived that there was an ideal opportunity to offer GPs the chance to develop their skills in this area:

**R1D:** GPs as well, at some point, will have to be tackled about, you know, this kind of old, you know, 'get my stick out and you will stop smoking' routine, just does not work. And those that don't do that routine and try and do it sensitively, and you know, in a kind of helpful manner, you know, you can see the difference. But I think there's a groundswell of work needs to be done with them. (**LHCC Management/Strategy/Co-ordination**)

**R2I:** Smoking is something you deal with on a daily basis, and we were just looking at giving people [GPs] some tools to deal with it in a more effective way, not suggesting that you need to take it on and do ten sessions of counselling with patients. (**Advisory Group**)

In some cases however, GPs were described by respondents as being supportive of their local smoking cessation services, and played an active role in referring patients on for intensive support. This was often done through active consultation about



patient treatment with the health professionals providing the intensive support within their Practices. Indeed, several interviewees commented on the support GPs had for local smoking cessation services. This support was perceived by health professionals to be reflected in the priority GPs attached to smoking cessation, and the efficiency GPs displayed in their role as referrers. This however was more likely to be raised by those working within a practice-based service rather than by those health professionals who provided centralised group support. This difference in experience of the GP's role as a referrer, could perhaps be attributed to the closer working relationship between the GP and the health professional providing the intensive support:

**R3E:** I mean the GPs are very good, because obviously, you know, we'll see them for smoking cessation, and you know with the patients, deciding what's probably a good remedy to help them stop, but it still has to be discussed with their GP, so they are very supportive. And obviously they see that stopping smoking is a priority, so they're very keen to help in any way they can with us.  
**(Service Delivery: practice-based service)**

However, in many cases GPs were described as playing a more of a passive role, with involvement limited to simply referring patients on for intensive support. Indeed, this was one of the key functions of the brief intervention and one of the principal roles of the health professional providing it (where referral for intensive support was considered to be appropriate). However, it was suggested that patients were sometimes simply referred on with little concern thereafter. One health professional who provided group support for his/her LHCC, and one-to-one support within his/her practice, described his/her role as 'isolated'. This health professional (R3D) generated the prescriptions, which the client's GP then signed. R3D discussed that s/he often recommended two different types of NRT, or a combination of NRT and Zyban. However, it was reported that s/he had never been challenged by GPs on her NRT/Zyban prescribing decisions for their clients. R3D appeared to attribute not being challenged to GPs' lack of interest (and knowledge) in smoking cessation interventions:



**R3D:** I've not had any of the GPs in the LHCC phone me to say 'why on earth are you prescribing that and that'. I've not had any of the GPs question my...or our decision- the patient and me- decision about what they're going to use- I've not had any of the GPs come back on that. So they seem to be quite happy that I know...probably more about it than they do. I think that's a fair comment, because the majority of them haven't taken the time to, you know, look into it that much. **(Service Delivery)**

Respondent R3D did note, however, that GPs had raised some concerns about prescribing costs. This, s/he suggested, was because s/he was keen for pharmacological support to be prescribed beyond the three-month period that the LHCC guidelines recommended. However, with regards to NRT and Zyban in the smoking cessation process, R3D posited that GPs were less knowledgeable. This lack of knowledge around smoking cessation interventions amongst GPs, as suggested by R3D, could be attributed to a lack of interest in smoking cessation more generally, and/or the perception that smoking cessation was within the remit of other health professionals' roles.

It appeared from the interview data that General Practitioners could act as 'gatekeepers' for service delivery. Specifically, this could occur through the control they exercised over the activities of practice nurses, whom they employ. Where GPs within a practice were less enthusiastic about providing a smoking cessation service, or considered it to be less of a priority than other issues at the time, for example, this could render the involvement of practice nurses in the delivery of intensive support problematic. The following extract is from an interview with a health professional from an LHCC that adopted a practice-based approach. S/he was one of a few health professionals who provided smoking cessation support for the practice area. This interviewee (respondent R5A) discussed how in the initial stages of service development there were a few health visitors on board to provide smoking cessation support. It was perceived by R5A that there was little funding available for the provision of services. Subsequently, R5A described how the health visitors within this Practice took time back (for the time spent providing smoking cessation support), as opposed to being paid directly. However, as the extract below highlights, it was perceived by R5A to be more difficult to utilise practice nurses for

smoking cessation support provision. This was because practice nurses were directly employed (and therefore paid) by the practice GPs:

**Int:** How difficult was it to get staff on board initially- was there quite a lot of support?

**R5A:** the em...the health visitors- no problem at all, everybody was very keen. The practice nurses, that was more difficult, because the GPs- because the GPs here are not part of the LHCC, they were very reluctant to even let the nurses have the time to do the training. **(Service Delivery)**

Respondent R5A went on to discuss how the funding that was initially set aside for the NRT voucher scheme was then used to fund the training and 'employment' of practice nurses:

**R5A:** So that was when eventually we got the funding, we applied for funding for them to have the training, and for them to do some work with us. They were very keen themselves, I have to say, they were really very keen, but the GPs were not, they were throwing obstacles in the path. I mean it strikes us as quite odd that they feel like that. They're quite happy for us to do the work within our own time, but they don't employ us, they employ the practice nurses, you know, so they didn't feel that they had the time...that was difficult. **(Service Delivery)**

Interestingly, interviewee R5A discussed how GPs had been supportive of the health visitors' efforts to establish smoking cessation support for the practice area. Specifically, the practice GPs provided funding for refreshment funds, smokealysers, and additional equipment such as flipchart paper and pens. On the one hand, therefore, it appeared that smoking cessation was considered by the GPs to be an important service. However, their reluctance to allow practice nurses the time to be trained in smoking cessation and offer to support, suggests that it was not a sufficient priority within the realms of 'GP time', or the time of their directly associated staff (i.e. practice nurses).

It is clear from discussion above that smoking cessation was not always understood as a priority for GPs. Consequently, other members of the healthcare team were described as playing a more significant role in the delivery of services. One

explanation for this could be that GPs did not perceive smoking cessation to be part of their role:

**Int:** What are your impressions of the kind of staff who are getting involved [in providing smoking cessation interventions]?

**R2H:** Health visitors and practice nurses tend to be the main ones. GPs are very slow to come on board, they seem to regard it as someone else's job, which is disappointing, because they're going to be the first port of call for a lot of people. (**Health Board**)

One health professional who provided smoking cessation support within her/his practice, described her/his perceptions of the priority that was assigned to smoking cessation by the practice GPs, and where it fitted within their work/roles:

**Int:** What was the kind of em...the overall kind of, I suppose ethos of the Practice when you took the smoking cessation work on? Were they quite supportive of the process?

**R4D:** I think they [GPs] thought 'great'. I think they thought, you know, I haven't actually discussed it with them, but I think – 'oh great, there's somebody that wants to do this, that's great, we're meeting targets, we're doing what we should be doing', and...they'll probably shout me down and say that wasn't the case, but that was how it kind of felt for me. Since then I've been asked to, I was given a couple of days notice, to write a report, so the Practice could get funds for it. And it all leaves me thinking, you know, 'where are we here?'. If this was a real commitment from the Practice, then they would have given me a couple of weeks to write a report, instead of two days. So I'm left, you know (Few Words?). I'm a nurse- I work with GPs- I mean there's a conflict. We have a great rapport here, it's great, but it's right across the board I think, nothing's changed from the days where nurses and doctors worked together. (**Service Delivery**)

The delegation of health promotion activity from 'Doctors' to other practice staff (e.g. Nurses) has been articulated widely in the literature around health promotion in primary care. Interviewee R4D cited above described how responsibility for smoking cessation had been delegated to him/her, and that smoking cessation was not perceived to be a Practice priority. R4D suggests, however, that GPs perceived smoking cessation as something that *should* be on their agenda, but which is not a high priority. Subsequently, the delegation of this activity to other practice staff was perceived by R4D as being one way of making sure that smoking cessation was 'seen

to be being done', while minimising the amount of practice time or resources used to this end.

Both the low priority assigned to smoking cessation, and a perceived reluctance for GPs to see it as part of their role, have implications for the provision of brief interventions by GPs. Specifically, several interviewees proposed that the brief interventions offered by GPs were not of an adequate standard. They claimed that this was due to the perception by GPs that someone else within the Practice would assume responsibility for tackling smoking cessation with their patients. For instance, respondent R1E cited below argued that GPs' lack of interest in smoking cessation training could be attributed to the fact that they felt they could delegate this aspect of their work to another health professional within the Practice:

**Int:** What are the brief interventions like with GPs?

**R1E:** not the best...well I'm not too sure. I mean we've had- we held a...there was a Public Health Doctor at Lothian Health who came out to sort of provide a session, which we were targeting at anyone, but mainly at GPs, and I think three or four attended...out of fifty. So that kind of gives you an idea that it's not top priority, and also that they know that there is someone else within the Practice who provides the service- they will probably just tell the person to go along. We do obviously try to encourage them- they will ask the question 'do you smoke' and 'you shouldn't, but I don't think in many cases it goes beyond that. (LHCC Management/Strategy/Co-ordination)

One health professional, R4D, commented on the informal feedback that s/he received from patients on how smoking cessation was dealt with by GPs. This led to R4D understanding that there was a general lack of commitment from GPs in dealing with smoking cessation appropriately within consultations. Several explanations for this apparent lack of proficiency in providing smoking cessation interventions were offered. This included a perception amongst GPs that smoking cessation activity could be passed onto someone else within the practice team:

**R4D:** But what I've picked up from the clients who have been to see their GPs for various reasons, there's a complete mish-mash of how this is being dealt with- smoking cessation- which, as I say, emphasises to me, is there an interest, is it meeting government

targets, is it about budgets, is it about income- what is the bottom line- is it about finding someone else to do your job for you, someone with an interest? **(Service Delivery)**

One of the reasons why GPs may have deferred responsibility for smoking cessation, in addition to a lack of interest, could be attributed to GPs' perception that the delegation of this activity was a more efficient use of time and skills. This was articulated by one health professional:

**R5B:** I always thought the key person [to provide smoking cessation support] was likely to be a nurse, because they're quite keen to do this sort of work, um...and relatively easy to define the set of skills for them to be trained, and to give them dedicated time once that's resourced- it's easier to quantify all of that. When GPs start becoming involved it all becomes very complicated and messy, and much more expensive. **(Service Delivery)**

The above extract raises a number of issues around the difference in perceived roles between GPs and the nursing profession. The reference to nurses as keen to do "*this sort of work*" suggests that health promotion activity might be perceived as nurses' domain. It also indicates the perception that it was easier to accommodate the time for smoking cessation within a nurse's workload, than in a GP's. This leads onto a further issue, which is how other health professionals such as nurses and health visitors perceived their role as smoking cessation providers.

#### **6.4.2. The role of other healthcare professionals**

As outlined previously, the majority of the intensive smoking cessation support was carried out by health visitors, practice nurses, and other nursing staff (e.g. primary care nurses). In three LHCCs, pharmacists also had a prominent role. It was clear that for those involved in providing smoking cessation support, smoking cessation was perceived as an acceptable part of their role, and as something that they were generally skilled to do:

**R3B:** Health Visitors are quite used to health promotion issues, and really, with a little bit of guidance, they can probably just change their own practice quite easily by just transferring skills that they use in other places. **(Service Delivery: nursing profession)**

One nurse reflected upon the different skill sets held by Doctors and Nurses. S/he perceived the latter profession to be more apt at dealing with the issue of smoking cessation.

**R3D:** I don't think doctors are as good at it (providing smoking cessation support) as nurses are. Nurses are better at bringing up the smoking side of things. Doctors tend not to ask questions, because the patients don't like being asked about smoking, and so they tend to sort of go 'I knew you would say that', or they'll lie about the number of cigarettes they have in a day. Whereas I think nurses are a wee bit more direct, and more likely to sort of probe a wee bit further...than just mentioning it. **(Service Delivery)**

This extract raises the issue of the different types of relationships and boundaries that doctors and nurses may have with their patients. In particular, it suggests that there is a perception that patients would be more comfortable with the issue of smoking being raised by nurses as opposed to their GPs. Additionally, it suggests that nurses may be more proficient in discussing this topic. The perception that nurses may be more adept at discussing smoking cessation with patients, could be attributed to the perception of GPs as having a more authoritarian approach to dealing with such issues with their patients.

It was also clear that interviewees recognised an agenda of change within the health visiting profession. Several health visitors discussed how they were transcending into more of a public health role. This meant that they were undertaking a broader range of health promotion and public health issues, such as smoking cessation.

**R3B:** Traditionally health visitors have been involved with families who've got children under five, and that's how people would see us. But over the last few years we've expanded our role to look at other at-risk groups. **(Service Delivery)**

Respondent R3B later added:

**R3B:** As time has gone on, [with the more?] public health agenda, we're looking at developing our skills in slightly different areas- and smoking cessation seems to be an area that...was completely



new, for me, but it seemed like it was something that was useful.  
(Service Delivery)

Clearly many of the health visitors, practice nurses and other nursing staff who were providing the smoking cessation support perceived smoking cessation to be an activity that (a) fell within their health promotion and public health remit, and (b) was compatible with their existing professional skill sets. However, there was a tendency for the responsibility of providing intensive support to fall heavily on such professions.

In three LHCCs however, pharmacy was also involved in providing intensive smoking cessation support. Within these LHCCs, pharmacists played a significant role in providing one-to-one and group support within their premises. The pharmacists interviewed discussed that smoking cessation support was a task that was already informally a part of their day-to-day role, particularly with regards to the role they played in providing (and advising) clients with NRT. Getting involved with their local services, therefore, was referred to as a natural progression within their professional role:

**Int:** Within [LHCC name] it was the pharmacy that was involved probably first, the very early stages. Why do you think there was a kind of push for pharmacy to get involved?

**R2D:** because I think we were already doing it informally. We were already advising people in smoking cessation, when they came in with prescription, or if they came in to buy stuff. So we were already doing it, it was just, this was a more formal way of doing it, and getting people into the system. (Service Delivery)

In those LHCCs that had a strong pharmacy input, this input appeared to work well for local services, in that pharmacy services fitted in with the service structure that had been created. For instance, in one LHCC, those pharmacists that were involved took it in turns to provide group support for the LHCC. This meant that there was a reliable and structured provision of support in place. Where LHCCs employed pharmacists to provide structured support, however, pharmacists were paid accordingly for their services. Unlike health visitors and practice nurses, there was



less of an expectation that pharmacists would 'take time back' for their smoking cessation activity:

**Int:** Are the pharmacists funded through the smoking cessation funds, or are they doing it...again as part of their...[core work]

**R1B:** No, what we've done is...the pharmacists, we have an agreement, they'll get paid a sum of money for doing a session a week of smoking cessation support, and we will fund that from our smoking cessation allocation. The health visitors, if they do work outside of their normal work, then they'll get paid...they get paid overtime in effect, for actually doing that work. And again that come out of our smoking cessation money. (LHCC

**Management/Strategy/Co-ordination)**

The above extract suggests that health visitors, more so than pharmacists, were expected to incorporate smoking cessation activity into their day-to-day work. Whereas pharmacists were paid directly for their services, health visitors were only paid for smoking cessation activity if it fell outwith their normal working hours. This difference in approach may be attributed to two factors. Firstly, those involved in managing/co-ordinating LHCC smoking cessation services may have perceived smoking cessation (and health promotion more generally), to be a part of a health visitor's (or other nursing profession) core work. Secondly, the position of pharmacy as an independent business may have required formal payment for services. Indeed, the payment required for recruiting pharmacists in one LHCC, was described as the key barrier to utilising pharmacists in smoking cessation service provision:

**R1F:** The people I've been probably most disappointed in is the pharmacists, because we trained them up- I think we trained about four or five of them up...

**Int:** right at the beginning?

**R1F:** Right at the beginning, but they can't come out in the evening. They...if they do come to do any work, they actually ask for a lot of money, you know, they don't have a sort of standard nursing rate, you know, they expect to be paid as pharmacists. So that runs away with the budget. (LHCC

**Management/Strategy/Co-ordination)**

It was apparent that pharmacists were perceived as having a potentially crucial role to play in the delivery of smoking cessation services. However, a proper support structure (including financial) was deemed necessary to facilitate the involvement of

pharmacists in service delivery. Thus, in the LHCCs where pharmacists played a prominent role, there were key pharmacy leads within the LHCCs, and a strong drive for pharmacy as a 'profession' to be involved. In LHCCs that opted for Practice-based approaches or were heavily focussed on just health visitors for providing support, it was less likely that funding would be directed at the involvement of this profession (pharmacy).

## **6.5. Chapter Summary**

This chapter has discussed four key areas pertaining to the role of personal and professional commitment in the development/delivery of smoking cessation services. Personal and/or professional enthusiasm for, and interest in, smoking cessation, was understood by respondents to provide significant momentum to service development/delivery within the LHCCs. However, there were variations with regard to how health professionals perceived smoking cessation as part of their 'core' workload. A reliance on 'goodwill' and staff enthusiasm/interest was perceived to be unsuitable for the longer-term sustainability of local services, and many respondents argued that services required dedicated staff to provide smoking cessation support and support/sustain local services.

Health visitors, practice nurses, and other nursing staff played an important role in the provision of intensive smoking cessation support, particularly intensive support. These health professionals, for the most part, perceived smoking cessation as falling within their professional remit and skill-base. GPs, however, were largely perceived as being ambivalent about their smoking cessation role, and as maintaining a certain 'distance' from smoking cessation activity. While some GPs had delegated smoking cessation to practice nurses and/or other members of the primary care team, others were described as having been reluctant to release members of their team for cessation work. Pharmacists were perceived as playing a prominent role in smoking cessation service delivery in three LHCCs. This role was described as being compatible with the work remit of pharmacists and in complementing their developing health promotion role.

# CHAPTER SEVEN

## Strategy Interpretation

This chapter discusses interviewees' perceptions around key strategic aspects of the NHS smoking cessation strategy. I have used the word 'strategic' to encompass discussions around aspects of the smoking cessation strategy that focussed on the role of The Scottish Executive and/or the Health Board. The two key areas highlighted by interviewees are outlined below:

**7.1. Funding and smoking cessation services**

**7.2. Monitoring/evaluation of smoking cessation services**

**7.3. Chapter Summary**

### **7.1. Funding and smoking cessation services**

Interviewees talked at length about the funding that was allocated for the development of Scottish smoking cessation services. This was highly pertinent with regards to how interviewees reflected upon their experience of implementing national policy at the local level, and two central issues were discussed. The first issue related to the perceived impact of limited funding on the development, delivery and sustainability of local services. The second issue pertained to a related, but broader, concern around the perceived priority assigned to smoking cessation at the national level.

#### **7.1.1. Funding and service development, delivery and sustainability**

Interviewees talked at length about the impact of funding on the ability of local smoking cessation services to be developed and sustained at a comprehensive level. In using the term 'comprehensive', I refer to respondents' expressed desire to have a smoking cessation service that was fully developed/structured, appropriately staffed, and able to meet service demand. There was a general consensus throughout the interviews that the money that was allocated to the LHCCs was insufficient to

develop and sustain comprehensive smoking cessation services. One interviewee argued that the level of funding was so inadequate that it was difficult to spend it in any constructive way:

**R1B:** You probably think 'oh [£6,000-£11,000]- that'll go like that!' - it doesn't, it's difficult to spend it because it's not enough to do anything with, do you know what I mean? We can't...because it's bits and pieces, and we end up with an under-spend, so we're like 'what do we do with this?', because it's not enough to actually do anything with, and that makes it more difficult to actually spend, because we can't employ anyone, we can't run things on a real formal basis because we don't have...you know...so it's strange the difficulty to actually spend that small amount of money. **(LHCC Management/Strategy/Co-ordination)**

Although each LHCC opted for different forms of service delivery (ie. Practice-based support; centralised LHCC support; combination of practice-based and centralised support), respondents across LHCCs reported similar frustrations with the level of funding allocated, and difficulties in developing a comprehensive service. The following data extract illustrates the problems experienced by one LHCC that divided the local smoking cessation funding allocation between local Practices:

**R4A:** But very strongly the Practice Forum were vociferous against this [dividing LHCC money amongst Practices], because what they said was the money didn't even start to support any kind of development of services. I think it worked out about- off the top of my head- something like the equivalent of £500 per Practice or something like that, initially. So basically what they were- they were vociferous in saying 'we're not doing this, because the money does not even start to come near what would be required. **(LHCC Management/Strategy/Co-ordination)**

Clearly £500 was considered by respondent R4A as inadequate for the development of a Practice-based service. However, as was discussed in chapter five (Service Development and LHCC Capacity), the LHCC elected to progress with service development in this way. The decision to develop a practice-based service was attributed by interviewees to the geographical structure of the LHCC and the lack of co-ordination by LHCC management.

Irrespective, however, of the form of service delivery (i.e. practice-based; centralised LHCC support), interviewees across all LHCCs expressed a similar frustration with the level funding that was provided for the development of smoking cessation services. Several key issues were raised, which will now be discussed.

#### ***7.1.1.1. Recurring funding and staff employment***

One perceived problem with the smoking cessation funding, was interviewees' confusion over its recurring nature. At the time the interviews were conducted (November 2002- April 2003), there appeared to be confusion and uncertainty amongst interviewees over whether the funding for the services would be recurring, and if so, how much would be available. This had implications for the development of the smoking cessation services, and affected interviewees' perceptions about the sustainability of services developed at the local level. One of the problems associated with a lack of recurring funding, was the capacity of LHCCs to recruit staff on permanent contracts. Specifically, several interviewees discussed the difficulties involved in recruiting staff within the context of service sustainability, when there was no guarantee of recurring funding for the services:

**R1B:** Again, because of the lack of funding we weren't able to employ anyone- A, there wasn't enough money, and B it was non-recurring- so we could only employ them for within the current financial year. We couldn't say 'you're in a job next year'. And an example- and I'll come back to this in a moment- an example is our funding for 2002/3 will- we were told about it last week, and we're in November (2002)- but we've been told now it's recurring funding. **(LHCC Management/Strategy/Co-ordination)**

Respondent R1B was clearly frustrated that The Scottish Executive and/or the Health Board did not inform the LHCC of its annual funding allocations in good time. This lack of clarity was perceived as having serious implications for service development and delivery. In the extract below, respondent R1C discusses the difficulties in employing dedicated staff when there were uncertainties around recurring funding:

**R1C:** It's wonderful that I've got her [smoking cessation worker]- I'm delighted. But, I can only employ her until the [date- 4 months from interview date], because my funding only goes to [date] and

today I'm still sending emails to the Health Board and to our financial management team at the Trust, trying to get sorted, whether this funding of [one word?] sum of [£ amount] is in fact recurring- and that is still being debated, right. **(LHCC Management/Strategy/Co-ordination)**

Uncertainty about the level of funding that would be available for the smoking cessation services in the longer-term affected LHCCs' willingness to employ permanent staff. It was clear from the interviews that there was much confusion around the funding arrangements for the smoking cessation services. When asked whether the funding would be recurring, interviewees were rarely able to answer with confidence. In addition to the obvious practical implications around employment issues, interviewees also argued that the lack of clarity over funding impacted upon the ability to plan how services might progress/develop:

**Int:** You see I thought the money was recurring?

**R4B:** It's not- well uhhh...

**Int:** Or maybe less than was expected?

**R4B:** Uh-huhh. It's definitely going to be less. It is...it is recurring, it's recurring to a certain degree- they haven't been told how much it is, and they don't know when they'll [LHCC management] get it. So I mean if you go on last year's proposal, it didn't come in 'til October. So what do you do between April and October...you know, who funds that? I mean the LHCC is funding that, they have agreed to pick up the bill between now and October, and then probably take it off, but...that, we shouldn't have to do that, they [Health Board?] should know- I mean how can you plan a service if you don't know 'A' how much you're getting, and when you're going to get it. **(Service Delivery)**

The data extract above (R4B) illustrates the perceived difficulties involved in planning local services, particularly when there was a lack of clarity surrounding the level of funds that would be available, and *when* they would become available. Interviewees argued that limited funding resulted in services being delivered at quite a basic level. Additionally, one interviewee discussed that the local smoking cessation service could not be promoted/advertised around the time of No Smoking Day, given a perceived inability of the service to deal with demand. In this case, therefore, demand was perceived as being constrained. Consequently, there appeared to be an understanding among interviewees that the availability of more significant,



and recurring, funds would allow for the development of a more comprehensive service.

Interestingly, one Health Board interviewee discussed that funding for smoking cessation was always *intended* to be sustainable, as part of Health Boards' core baseline budget. It is important to note, however, that this interviewee's perceptions of the recurring nature of smoking cessation funding were not so clearly advocated by other Health Board employees. It may not, therefore, be fully representative of the Health Board's position regarding this issue:

**Int:** I know the ring-fenced money ended in March this year...wasn't it?

**R3I:** Yes

**Int:** What's the funding situation now?

**R3I:** Well the money was actually always part of the baseline budget for the organisation. And I think the manager who's in charge of that has actually looked at it just being part of the core budget. And it will be allocated to the Trusts in just the normal way, as part of a baseline budget. But again you'd need to check that with...so I mean it's, it's been sustainable from the outset, because it was part of the Board's allocation. I mean, when it came out it sounded as though it was new money coming in, then the next letter said no, it's part of your allocation', so you have to identify it from that. So it's always been there. But whether the Boards choose to use it in that way. **(Health Board)**

Respondent R3I's impressions of the funding situation, therefore, differed from those staff working on the ground. The issue of funding was clearly a confusing one for the majority of interviewees. It was difficult, however, to establish from the interviews the exact reasons for the apparent lack of effective communication between the Health Board and the LHCCs regarding funding issues. As indicated by interviewee R3I above, beyond the ring-fenced period, Health Boards could clearly have their own agenda for using the money 'allocated' for smoking cessation. Another interviewee also commented upon Health Board agendas. In the data extract below, s/he was commenting upon the use of Health Improvement Plan monies (from the tobacco tax), by Health Boards:

**R11:** Gordon Brown had hypothecated tax, in other words had taken so much back from the tobacco tax, putting it back into health for the first time, and Scotland got £26 million. And a proportion of that was, well, a proportion of that was supposed to be prioritised for cessation services. Now, I spoke to the then Health Minister Susan Deacon, who said ‘no no no, Health Boards have got to prioritise cessation’. You get down to the Health Board level, and they say ‘no no no, that’s not how we see ourselves spending the money’. So there’s a conflict almost between national policy and how people see it on the ground, and how a Health Board will prioritise smoking, where it comes in the hierarchy of service. **(Advisory Group)**

Respondent R11, therefore, perceived there to be a discrepancy between national policy and ‘local’ interpretation of this policy. It also highlights the potential power that Health Boards are perceived to have over the implementation of national policy, particularly regarding the application of funding to appropriate services. R11 appears to suggest in the data extract above that funding would be allocated to smoking cessation according to how much of a priority it was perceived to be by Health Boards.

#### **7.1.1.2. Targeting**

There was very little direct targeting taking place within the LHCCs, although chapter five (Service Development and LHCC Capacity) discussed the circumstances of one LHCC (LHCC ‘G’) that was more progressive in this regard. Chapter eight (Interventions) discusses the ‘targeting’ issue further still. Discussions around targeting in chapter eight are couched strongly in perceptions of demand, appropriateness of the primary care setting, and ethical considerations. This section, however, discusses how a lack of comprehensive targeting was also perceived to be a casualty of limited funding.

Several interviewees expressed frustration at the way in which the smoking cessation funding had been allocated at the Health Board level following the White Paper. *Smoking Kills* highlighted that services should be targeted at young people, low-income groups, and pregnant women. However, as was discussed by one interviewee, the funding decisions made at the Health Board did not reflect this:

**R1H:** The work that is happening is not really what the Government intended. The Tobacco White paper came out, with the emphasis supposed to be on pregnant women, low-income groups, and young people. And primary care, fair enough, you have to get them set-up, and yes it does address low-income groups, it could potentially address pregnant women and young people, but, it doesn't. And the way I see it is that the money's not actually being spent the way it should be being spent. It should be being spent on these target groups. But actually the demand from people out there like the hospital trust, and primary care, has been so great, that we've [Health Board] ended up getting sucked-in by that, and we're spending our time working with the...rather than what we should be working with, which...and I mean it's happening everywhere. It seems to be that across Scotland, that's the way people have been pulled in, and also in England there's a lot of emphasis on primary care and secondary care. And really...if everything had gone the way the tobacco white paper had intended, they...the hospital trust would have identified their own funding to do smoking cessation. Primary care would have worked within their existing budgets, prioritised smoking cessation, be working in that, and the Tobacco White Paper money would be spent solely on pregnant women, low-income community-type based approaches, and young people. **(Health Board)**

R1H above discussed the demand that came from primary care for funding to develop services. As discussed in chapter five (Service development and LHCC Capacity), the availability of Zyban was perceived to be a key factor underpinning the development of smoking cessation in primary care.

Chapter four outlined that the smoking cessation funding was divided-up between the LHCCs for the development of local services. One Health Board employee discussed that LHCCs were strongly encouraged to develop services to meet the needs of the three target groups. However, as one interviewee discussed, the funding was not allocated to LHCCs on the basis that they develop services to *specifically* meet the needs of these groups:

**R2I:** I don't think that when the money went out to LHCCs, it went with caveat, to say this should be towards...em...those specific target groups, which, you know, if you look back to the beginning of setting up the advisory group, we probably should have said 'right, we've got this money, these are the three target

groups, we should do three different things with three target groups', but it wasn't. It was very much divvied up for [Health Board]-wide basis. (**Advisory Group**)

Respondent R2I went on to reflect upon the lack of funding allocated to LHCCs for the development of services, and the impact of this funding on developing services to meet the needs of the target groups:

**R2I:** And I think we [Health Board and Advisory Group] lost sight a little bit of the fact that we were dealing with really quite a small amount of money, and when it came down to sort of the number of smokers in [Health Board area], we were...it was a very small amount of money- it was £140,000 over three years, wasn't it. So divide that down per year for the whole of [Health Board area]- it's peanuts really, and we should have really been looking at doing- in retrospect- doing a much more targeted thing to a particular area, to a particular group of people, rather than trying to spread it so thinly. (**Advisory Group**)

Thus, given the relative lack of funding for the development of smoking cessation services, R2I argued that a better use of this funding might have been to direct it at targeted groups of people.

There was a general consensus among interviewees that in order to reach the target groups effectively, additional funding would be required to develop a more specialist service. One reason put forward for this was that the funding that was available was only perceived to allow for the development of a limited and basic smoking cessation service. The following extract illustrates the difficulties experienced by one LHCC, although it strongly reflects what was happening within other areas also:

**R1B:** On the surface we aim to try to prioritise those women who are pregnant, young people, and so forth...on the surface. In practice it doesn't tend to happen. We're relying partly obviously on the referrers actually completing information- that's not always the case. The funding again doesn't allow us readily to cherry-pick the ones that we actually want to attend a particular group. We tend to put people onto a list, and as groups come along, depending on where they live- we tend to do it more sort of postcode, simply to encourage people to come along. We'll have an event close to where people- a group of people live, and it tends to be that. But all of our smoking cessation support providers are aware that we

should be looking at these target areas, but in practice, the truth is...I don't know that that actually happens. (LHCC Management/Strategy/Co-ordination)

In the above data extract respondent R1B suggests that health professionals were aware of the requirement to target young people, pregnant women, and low-income groups. However, the funding was perceived by R1B to be a stumbling block in facilitating effective targeting strategies. Consequently, R1B argued that the local service tended to provide for the 'convenient' pool of smokers presenting for smoking cessation support. This was a perception shared by interviewees across the LHCCs. Interview R1B, went on to discuss what would be required to effectively target the priority groups. One suggestion made was that dedicated staff should be employed to concentrate on meeting the specific needs of the target groups:

**R1B:** If we had somebody dedicated to do smoking cessation work, that would certainly... It certainly happens in [LHCC name], and we would feel that if we had somebody in...dedicated to do this- well by dedicated I mean somebody especially employed to do it, because they're all dedicated doing this- but somebody especially employed to do this, then that individual could actually ensure that that actually happened. Because this is all just part and parcel of everybody else's job, and it's wee bits of this, wee bits of that, it doesn't truthfully happen. (LHCC Management/Strategy/Co-ordination)

The above data extract highlights the link between funding, staffing, and targeting, and reiterates discussions around core work and dedicated staff that were outlined in chapter six (Personal and Professional Commitment). R1B proposed, therefore, that a dedicated person was required to direct more meaningful efforts in the targeting or "cherry-picking" of the target groups. However, the funding allocated for the development of local services was considered by many interviewees to be insufficient to allow this to happen.

Clearly, there was a high degree of frustration expressed around the level of funding that was provided for the development of services. In particular, the level of funding that was allocated was largely perceived to be inadequate to develop and sustain services in the short and longer term, and to effectively target the three priority

groups. Also central to this frustration, however, was the perception that the level of funding did not reflect the priority that was outwardly ‘tagged’ to smoking cessation at a national level. The following section addresses this issue.

### ***7.1.2. Funding and perceived priority of smoking cessation***

Respondents discussed that the funding allocated for the development of smoking cessation services was insufficient to raise the profile of smoking cessation to a level that it deserved. Specifically, respondents were sceptical that smoking cessation was afforded the national priority that (a) was claimed for it by The Scottish Executive, or (b) that it warranted. For instance respondent R11 commented upon the low level of input directed at cessation, in comparison to the enormity of the health impact of tobacco in Scotland:

**R11:** Now if you look at Scotland, and you look at we’ve got 13,000 Scots dying from tobacco related diseases and we know that most smokers, 70% of smokers want to stop, and you’ve got one worker in one region [Health Board smoking cessation co-ordinator] trying to deliver to those smokers, then the services are very very poor. So you have almost lip service, I would say to you, to what’s happening in tobacco, and certainly around cessation.  
**(Advisory Group)**

Respondent R11 was reflecting on the priority of smoking cessation in Scotland more generally. Clearly, this respondent understood smoking cessation to be less of a national priority than was necessary to tackle tobacco-related health problems in Scotland.

A lack of priority at the national level was perceived to impact upon local prioritisation decisions at the Health Board level. Interviewee R1C below was commenting on the Health Improvement Plan (HIP), which is a yearly strategy document produced by each Scottish Health Board. The HIP highlights areas for prioritisation and investment within the Health Board. In addition to reflecting local priorities, the HIP would also take ongoing national priorities and strategies into consideration:



**RIC:** I haven't got this year's Health Improvement Plan (HIP) to check, but I understand that there is something like one line in there on smoking cessation, and I think that would be very important for your research to actually go through it and see if I'm lying- because that's what I've been told, I haven't gone and checked it out for myself, right. If there is only one line in there, right, it is not a priority. If it's not a priority, why are people expecting this service to be available, because money always follows priorities identified in the Health Plan. And the reason it's not a priority in the Health Plan must be that we're not getting the message from the Government that it is a priority, right. **(LHCC Management/Strategy/Co-ordination)**

Respondent RIC argued that a lack of smoking cessation prioritisation in the HIP reflected the limited priority assigned to smoking cessation by the Scottish Executive. It was argued by interviewees that the level of funding allocated for smoking cessation, did not allow for the development of the comprehensive smoking cessation services that were promoted at a national level. Respondent RIC proceeded to reflect upon the funding that was allocated for the development of local services within the LHCC:

**RIC:** One of the problems for me in terms of providing this [local smoking cessation service] is I get a bit frustrated because I hear that the Scottish Office has given lots of money to smoking cessation, that it's a priority, we all read about it in the newspapers and all of that. And I...as part of my job, had to look two ways. I look to [the Health Board] and I look to my staff who are running the service, and what I see is a lot of activity- when I'm looking outwards. **(LHCC Management/Strategy/Co-ordination)**

RIC went on to add:

**RIC:** I then turn around and look towards the staff in the LHCC, and I say 'how on earth are we meant to provide this?' You know, that...I'm almost lost for words there...that is your fundamental problem, because the expectation and perception, and reality, are just so different. **(LHCC Management/Strategy/Co-ordination)**

The above data extracts (respondent RIC) highlight the frustration expressed by many respondents over the level of funding that was allocated for developing local smoking cessation services. The perceived inconsistency between the level of

funding allocated and the promotion of smoking cessation as a 'national priority', was one of considerable contention amongst interviewees:

**R1B:** I suppose what I'm saying is they [The Scottish Executive] should put their money where their mouth is. Don't come up with all the politicising, saying 'we encourage people to stop smoking, we say you can do this, we say you can do that'. Give us the money, and then say that, you know, give us the money first. And it's...it seems dreadful that I'm constantly talking about funding, funding, funding, but that to me is the only way. If we were all given the funding to do the job professionally, the benefits would be tremendous. **(LHCC Management/Strategy/Co-ordination)**

With regards to the issue of funding, interviewees *also* discussed where they perceived smoking cessation to sit as a national priority in relation to other health strategies. Several interviewees discussed the way in which *Smoking Kills* had raised the profile of smoking cessation. In the following data extract, interviewee R1H proposes that following the White Paper, smoking cessation became an issue that people *wanted* to tackle, as opposed to being on the periphery of health professionals' priorities/ interests:

**R1H:** When the tobacco White Paper came out, I can see that there's changes definitely happening there, you know, there's no doubt about it, and we do have people coming to us saying 'we want to do smoking cessation', rather than us constantly having to fight our way in, and people going 'oh sorry, but we've got sexual health things to do, and that's more important'. **(Health Board)**

Several respondents expressed the view that *Smoking Kills* had raised the profile of smoking cessation. However, although there was some recognition that smoking cessation had claimed 'space' on the health agenda, many respondents argued that smoking cessation (and 'smoking' as an issue more generally) was still a comparatively low priority. It was common for interviewees to compare the money that was allocated for smoking cessation to the funding that was provided for drug, alcohol and sexual health strategies. In the data extract below, respondent R3D compares the resources provided for smoking cessation services (in terms of staff, time, and funding), with that provided for other health strategies:

**R3D:** I don't think there's a political will either. I think that's really the crux of it. I mean the Government says there's a political will, and they're giving us all this money for NRT, but no...when you look at the amount of money that's spent on ...drug addicts for instance, proportionally, drug addicts are on methadone, and the amount of staff and time that goes into this, and then you look at the amount of time and staff that is dedicated to smoking cessation, there's no comparison, and yet the costs to the health service of smoking are huge...you know, compared to drug abuse. So, you know, I really don't believe there is a political will to make this more of an issue. **(Service Delivery)**

Interviewee R3D above therefore argued that the money allocated for the development of smoking cessation services did not reflect the priority that was outwardly assigned to smoking cessation by the Government. In considering the higher levels of funding that was allocated to drug services, it was perceived that smoking cessation was not as high a priority as other health strategies.

Respondent R1H, below, discussed how smoking cessation had to compete with a range of other priorities put forward by The Scottish Executive. Consequently, it was perceived that other 'newer' strategies/issues coming onto the public health agenda could potentially relegate the position of smoking cessation as a priority issue in primary care:

**R1H:** I do think, slightly, it's [smoking cessation] beginning to be seen as 'well that was fashionable, but now other things are', when actually smoking comes into everything- whether it's parenting, or whatever the new thing is. So they're [Scottish Executive] saying one thing.....it's interesting that whenever...they keep saying it's a priority, but they're also saying all these other things are priorities as well, which fair enough they are, I know, but the problem is that the more they give across that all these other things are priorities, the more smoking gets watered down. **(Health Board)**

At the GP practice level, several interviewees perceived that although *Smoking Kills* had initially raised the profile of smoking cessation, the priority assigned to smoking cessation at The Scottish Executive/Health Board level had diminished over time. For instance, in the following data extract, one interviewee discusses the difficulty in

maintaining the profile of smoking cessation, given a perceived influx of additional priorities advocated by The Scottish Executive:

**R1E:** I think the problem with health it that we've got so many priorities. I mean you look at the ones that come from the Scottish Executive, and you get them every week almost with another one, and I think...it's there on the list, it's there as a priority, it is [one word?], but slowly, you know, it moves down, and you link it in with Chronic Disease Management as a way to sort of keep it up in the list. **(LHCC Management/Strategy/Co-ordination)**

The above extract raises the issue of Chronic Disease Management (CDM), within which discussions of smoking cessation were commonly couched. In particular, interviewees reflected upon the funding allocated for developing strategies to combat chronic conditions such as heart disease and diabetes. It was proposed by R1E in the previous extract that smoking cessation might be incorporated into a CDM programme in order to maintain its profile. However, several interviewees argued that smoking cessation deserved a higher priority within CDM given the contribution of smoking to many chronic conditions:

**R4B:** We only have a limited amount of time, and therefore if cardiovascular disease, diabetes, stroke, etc etc are a priority, you know, smoking covers all of these things, I mean that's what nobody understands, that smoking, people who smoke are much more prone to all of these things, and therefore to treat the smoking bit would be a huge improvement in all the other things. But the funding's gone into all the other things, and then smoking's been left alone, you know. **(Service Delivery)**

Interviewees therefore expressed frustration, as well as confusion, around the limited investment in smoking cessation, particularly given its central role in chronic disease management. This low priority assigned to smoking cessation was, in turn, perceived to impact on the ability of LHCCs to prioritise smoking cessation at the local level.

Another issue, however, that was perceived to impact upon the prioritisation of smoking cessation at the local level, was target-setting. Several interviewees discussed how 'hard' targets were set for other health strategies, but not for smoking

cessation. Moreover, whereas in England, annual through-put targets (and the official monitoring of 4-week quit dates) were set for the smoking cessation services, this was not the case in Scotland.

The data extracts below highlight the perceived impact of Scottish Executive target-setting on the prioritisation of smoking cessation at the local level. Areas of highest priority were perceived by respondents to be those for which the Scottish Executive required specific targets. This had the effect of rendering smoking cessation less of a perceived priority:

**R1E:** But other areas, you know, you've got targets in other areas, you know, we don't really have specific targets for smoking cessation. You know, there's no 'you must get 90% of people...' you know, because you can't...I don't know whether that would come, whereas we can have targets for instance with diabetes- that Primary Care will see 60% of non insulin dependent, and there's not that kind of thing there [for smoking cessation]. **(LHCC Management/Strategy/Co-ordination)**

**R1C:** I'm told that when [the Health Board] have to report back to the Scottish Office [The Scottish Executive], what the Scottish Office are really interested in are things like...em...waiting times, CHD- smoking never is high enough up there. And until it's high enough up in our Local Health Plan, we will never get money identified for it, to have dedicated staff or proper resources. **(LHCC Management/ Strategy/Co-ordination)**

The Local Health Plan, discussed by respondent R1C above, is a strategy document produced by the Health Board, which outlines key areas of priority and action. R1C clearly perceived a lack of prioritisation of smoking cessation at The Scottish Executive level to impact upon prioritisation of smoking cessation at the Health Board level.

This section (7.1) has discussed the frustration that interviewees expressed over the perceived lack of funding directed at smoking cessation services. This lack of funding was perceived to impact negatively on the ability of LHCCs to develop comprehensive and sustainable smoking cessation services. Additionally, smoking cessation was commonly perceived to be less of a national priority than was

suggested by The Scottish Executive. Together, these factors were perceived to render the implementation of the national smoking cessation strategy at the local level difficult.

## **7.2. Monitoring/Evaluation of smoking cessation services**

This final section of the chapter will explore interviewees' perceptions of the Health Board' system of monitoring/evaluating the local smoking cessation services. The monitoring and auditing of the smoking cessation interventions was a recommendation outlined in *Thorax* (Raw *et al.*, 1998a), and the *Smoking Cessation Guidelines for Scotland* (HEBS & ASH Scotland, 2000). Given the importance attached to the monitoring process, it is crucial to consider how it worked in practice and also interviewees' perceptions of the process. As discussed in Chapter two (Literature Review), there was no standard audit form used in Scotland at the time of the interviews, and each Health Board was assigned responsibility to develop its own audit form for the monitoring and evaluation of local services.

The guidance of the Health Board involved in this research stipulated that the 'quit date' for smokers should be set for the second week of intensive support, and health professionals providing support were required to record smoking status at the end of an intervention. A further one, three, six and twelve month post-intervention follow-up of smokers who had received intensive smoking cessation support was subsequently required by the Health Board. The one-month follow-up, which was carried out by the health professional who provided the smoking cessation support to the patient, was achieved by telephone or questionnaire. The subsequent three follow-ups were conducted by the Health Board using similar methods, but mainly questionnaires. The Health Board provided LHCCs with 'outcome data' on (approximately) a quarterly basis. This outcome data detailed the number of patients receiving smoking cessation support (and the type of intervention provided) and self-reported quit rates, within each LHCC.

It was difficult to establish the extent to which the Health Board formally perceived the audit process as a method of service *evaluation* (i.e. to formally establish the



effectiveness of interventions and to feed back into service development), or simply as a monitoring procedure. When asked about how the Health Board used the audit form, one Health Board interviewee, who was closely involved with the monitoring procedures, responded that it would be useful to reflect upon the audit data for both cessation figures and service development purposes. However, there appeared to be a lack of clarity around the precise purpose of the audit form:

**Int:** What is the [Health Board's] expectations of what these forms will be used for. Do you expect it to be for to secure extra funding or...development...?

**R1H:** Well...I mean I suppose it's because we've been asked to provide this for The Scottish Executive, and [the Health Board] probably told the LHCCs so often 'this is for The Scottish Executive, not for us', sort of thing, that [the Health Board] has probably lost sight of what we really intended it for- other than evaluation, and to see- It would be brilliant to work out the numbers of people in [Health Board area] who've actually stopped, and how many smoking-related diseases that might have prevented, and all that sort of thing. But I just think it's important to monitor and evaluate everything you do, because...to see if it could help us [Health Board] work out- I mean if we could work out that actually services that were groups might work better, or...I mean it's unlikely that groups or one-to-one have a huge difference in terms of what's effective, but it's really good just to know the numbers of people going through. And also where there might be gaps as well.  
**(Health Board)**

Respondent R1H referred to the Health Board's monitoring process as a form of service "evaluation", and reflected upon the potential usefulness of the monitoring process for establishing cessation figures, in addition to informing service delivery. However, R1H did not clearly define the precise function of the monitoring process, and referred to the Health Board having "lost sight" of the intended purpose of the auditing process. Interviewees often used the terms 'monitoring' and 'evaluation' synonymously. There therefore appeared to be a lack of clarity around the issue of monitoring/evaluation, and there was a lack of discussion by Health Board staff about how the audit data was being used for purposes other than for service monitoring. This was also supported by LHCC respondents' accounts. That is, discussions focussed on the requirement to conduct one-month follow-ups and complete/return audit forms, the purpose of which was commonly perceived to be for

*monitoring* purposes. This, however, will become clearer as I discuss interviewees' perceptions around the process, impact and perceived value of the auditing/monitoring process.

### **7.2.1. Practicalities**

It was clear from the interviews with those staff involved in offering smoking cessation support to patients that the one-month follow-up was perceived as a time-consuming process. Initially, it was the health professional's role to conduct the three-month follow-up, although this was later taken on by the Health Board due to the difficulties staff encountered in following patients up. The main issue with the monitoring process reported by interviewees, was the personal time involved in contacting patients.

The following data extract is taken from an interview with a primary care nurse who worked in an LHCC that had opted for a Practice-based approach to providing smoking cessation support. Given that the service was based within the interviewee's practice, it was possible to check the patient's medical notes in order to ascertain whether a patient had continued to quit smoking. In an LHCC-based service, this would not have been possible. This was due to the fact that patients would come to a smoking cessation group from various Practices throughout the LHCC:

**R3E:** I find it [audit form] a nuisance, because it's very very time consuming. You pick up you patient's notes, you're going through them- 'have they seen the doctors, are there any notes in there about whether they're still smoking, or...have they remained stopped?' You try to ring them up- the phone doesn't...telephone number that you've got doesn't, you know, ring. You've got to go back [few words?] probably changed again- they've moved. It's just a nightmare. And I...it's trying to remember that I'm supposed to follow them up in a month, and then I think 'oh gosh, I've missed that one'. So I have to say the follow-up's not as good as it should be...certainly for me. (**Service Delivery**)

The interviewee's Practice was located in a relatively deprived area. Consequently the interviewee explained that patients tended to move house more frequently than usual, and could subsequently be more difficult to contact. However, the time-

consuming nature of the one-month follow-up procedure was widely discussed by interviewees across the LHCCs, despite differences in LHCC services. Thus, the data extract above reflects a sentiment that was commonly expressed by health professionals conducting the one-month follow-ups.

The previous extract (interviewee R3E) also highlights another important issue, which is the inconsistency with regards to the way in which health professionals conducted the follow-ups. Interviewee R3E reflected on how her colleague might have been more efficient at conducting the follow-up procedures. Indeed, several interviewees discussed that there were variations in the way in which staff carried out the follow-ups across the LHCCs. Additionally, due to the difficulties associated with contacting patients, it was recognised that not all follow-ups were 'timely' (i.e. conducted at the four week point):

**R2H:** The one-month follow-up can prove quite difficult, especially for people working in low-income areas, because if they do the one month follow-up...a telephone call...they maybe get kind of caught-up in quite a long conversation because they're talking to somebody who's maybe got a lot of issues, and they're wanting to be supportive. So there are time implications there. But what I also found out the other day was that because the practitioners are so busy, sometimes the one-month follow-up might not take place until three-months after the end of the intervention. So what we're getting back as the one-month follow-up, is maybe more like three months. **(Health Board)**

The laborious nature of conducting the one-month follow-up was therefore a source of particular frustration. One interviewee, however, discussed that s/he did not perceive any real difficulties with the follow-up, but *did* dislike the way in which the audit forms were subsequently dealt with by the Health Board:

**R4B:** I don't have a problem filling in the forms, but that's maybe just my nature. I know some people find it quite onerous, keeping track of them...the actual evaluation forms- I don't, I don't have a problems with it at all, but it's the em...[one word- my?] nature, that way inclined, and I know some people aren't. So I don't have a problem with the forms- I do have a problem with the way they're treated. **(Service Delivery)**

Many interviewees claimed to be similarly frustrated with the way in which the Health Board dealt with the audit forms. This will be discussed further in the following section.

### **7.2.2 Efficiency and utility of feedback**

The LHCCs received feedback from the Health Board regarding all four follow-ups (1, 3, 6, and 12-months), usually on a quarterly basis. Feedback was received in the form of a report outlining the number of patients that had received smoking cessation support in each LHCC. This was broken down by intervention type (i.e. group/one-to-one and NRT/Zyban), and by the number of successful ‘quitters’ at each of the four follow-up stages. Many interviewees, however, expressed discontent with the way in which the audit forms were dealt with by the Health Board. This discontent was directed, in particular, at the type of feedback that LHCCs received.

Some interviewees argued that the feedback that they received from the Health Board was not timely, and did not reflect the input and effort made at the individual LHCC level. For instance, the following extract indicates frustration around the quality of the Health Board’s ‘smoking cessation outcome data’ report:

**RIC:** There were lots of things that weren’t right on it, you know, and it was basic things like that, and we were told ‘well yes, we’ll get it right and we’ll send it out’. And at the last meeting we were told ‘yes, it’s almost ready to come out’, but it’s becoming ...big, laborious, slow, and who cares anyway- because if you look at it, I could be wrong, but I think the one that came out last time from [Health Board], it actually was something like 25% of the forms are non-allocated to LHCCs. Now, why am I doing all this work, if we’re not getting the credit for it. **(LHCC Management/Strategy/Co-ordination)**

Respondent RIC cited above argued that the feedback was inaccurate and failed to account for all the forms that had been sent to the Health Board from the LHCC. Interviewees from other LHCCs also discussed how a substantial amount of their one-month audit forms were unaccounted for in the follow-up figures received from the Health Board. Although it was unclear what had happened to many of the forms (e.g. lost; merged with data from other LHCCs), some respondents were clearly

frustrated that their work had not been formally recorded. It is possible that the perceived inaccuracies in the feedback provided by the Health Board could have been attributed to errors by 'on-the-ground' staff in the accurate completion and return of forms. However, as the following data extract suggests, there were health professionals who perceived themselves as efficient in the completion and return of audit forms, but expressed frustration at the Health Board feedback:

**R2A:** I mean they're [audit forms] only as good as what feedback you would get back from them, so I...I don't fill them in any longer for it, I've stopped doing it. It's no use to me, I don't- you know if I'm not getting any feedback, I'm not interested in doing it. It's just extra work for me. (**Service Delivery**)

Respondent R2A later went on to add:

**R2A:** I just audit my own work, and I don't send it sort of [few words?], and maybe, perhaps they need to do that. Either show you how to do it yourself, and then collate it all and send it out there, rather than it getting sent out there and getting lost. I mean I actually did ask for some of my stuff back from them, because I wanted to audit it myself, and they didn't have the information. They couldn't supply me with what I'd sent them out.

**Int:** So you just keep the audit forms for yourself now?

**R2A:** I just keep it myself now, and do it for myself.

**Int:** Right

**R2A:** I'd imagine other people are the same in terms of sort of 'why do you write a form out when you're getting no feedback from it...really?' (**Service Delivery**)

The above data extract highlights an important point about the relationship between the perceived quality of a monitoring process, and its subsequent usefulness to health professionals. Clearly, where the feedback data was not perceived to be accurate or representative, it was rendered insignificant as a source of reference. Interviewee R2A, in the extract above, said that s/he undertook his/her own patient auditing, although this did not appear to be common practice amongst interviewees who provided smoking cessation support. A couple of interviewees however discussed that they sometimes followed-up their own patients on an informal basis. This was more likely if patients were registered at the health professional's own GP Practice. Interviewee R2A, cited above, claimed that personally taking control of the

monitoring process was a more reliable method of evaluation. This was also echoed by other respondents. The following extract describes one interviewee's concern over not having access to 12-month follow-up data for the LHCC:

**Int:** Are they [Health Board] still doing the 12 month follow-up as well?

**R1C:** They should be, but I've not seen the results of that, which concerns me, because we have been going I think 2 years now- I think we're 2 years in November. We certainly should see 12 months, and I haven't...I'm sure I haven't seen any 12 month figures. So I've got real concerns that my figures...because I'm not in control of them- that's something else, if we were in control of our figures, and I think I would almost like to be, then I would have more confidence in them. **(LHCC Management/Strategy/Co-ordination)**

Although the service had been up-and-running for almost two years, the interviewee R1C above reported a lack of access to 12-month follow-up data. The perception that feedback was untimely was shared by several interviewees. For instance, one respondent argued that despite the time and effort required of staff to complete the follow-ups, there appeared to be little benefit or reward for doing so:

**R2F:** I think it's [monitoring feedback] actually de-motivated some of our staff, and this is where, and again a lot of these things are extremely personal opinions, but I know from our own practice nurses' point of view, when to begin with they were seeing a lot of patients, they were filling in these forms, their complaint was that the forms, the form-filling was actually taking away from the time they had. They were sending them off and then they weren't getting any feedback for months. And although we've had feedback for [Health Board] as a whole, it's months out of date, and it's not specifically, you know. If- it would have been nice for individual members of staff to actually get feedback on their success rates. **(LHCC Management/Strategy/Co-ordination)**

The data extract above (R2F) highlights another issue that several interviewees raised, which was the lack of *personalised* feedback. That is, the Health Board outcome data was provided on an LHCC-wide basis, and not broken down by Practice or smoking cessation group. Some interviewees, however, proposed that more personalised feedback would allow them to assess service efficiency/effectiveness at a more practical level. The following section will discuss



interviewees' perceptions about the *value* of the Health Board evaluation in more depth.

### **7.2.3. Perceived value of the Health Board Monitoring/Evaluation**

Many respondents questioned whether the monitoring feedback provided accurate data about quit rates. Interviewees expressed particular concerns about the accuracy of the follow-up figures due to a reliance on self-report measures. They also suggested that because follow-ups were conducted via phone or questionnaire/letter, this rendered the results less than accurate. In particular, interviewees argued that patients may not want to admit that they had relapsed. There was also a recognition that reports were not CO validated, and that there was therefore no clinical measure of validity. Furthermore, beyond the accuracy of self-reports, there was also concern around the number of successful follow-ups that were actually carried out. Interviewees therefore questioned whether the results were representative of the wider population of smokers who went through the smoking cessation service:

**R1F:** And they're [Health Board] using questionnaires- I don't know how many questionnaires they get back. So that's another thing, if they're only getting 10% back, the 10% they get back may be fantastic, and maybe they've lost all the rest. So I don't know how accurate the figures are- they could be absolute rubbish.  
(Service Delivery)

**R1B:** We get data every now and again to say that 'you had 200 went through in the last six months or something, and at the three-month point 50% or 60% had stopped, or continued to stop, and 10% had gone...', you know. I'm not sure how robust those figures are, because if it's just done on a telephone call, you can say anything on a telephone call. We're not asking individuals to come in and blow into a CO (Carbon Monoxide) monitor every time, but certainly feel that a face-to-face consultation is the only way to establish that. (LHCC Management/Strategy/Coordination)

Although it was argued that it was not practical for all patients to be followed-up using a CO monitor, many interviewees suggested that a more robust method of follow-up was required. Interviewee R1B, went on to highlight a need for more adequate resources to be 'earmarked' for conducting more thorough follow-ups at

the local level. R1B suggested that the evaluation should be an extension of local smoking cessation services, and should be expanded to become more than just a number-crunching exercise:

**R1B:** We would love to be able to provide what we'd see as a normal professional health- health professional's service for smoking cessation, which includes people earmarked to do this, earmarked to link with the Practices, to do the co-ordination work, to link with individuals, to do all the proper follow-up, rather than thins ...current method of audit that we do, where the provider does it up to the end of one-month, and then if goes off to somebody- well not somebody- it goes to [Health Board], who then probably at the end of the three months pick up the telephone- 'Joe Bloggs, how are you doing, how many are you smoking today?'- 'oh, I'm not smoking'- 'thank you very much'. That is not audit work. The only way that can actually work effectively is to have a face-to-face with the individual, at the three month point, at the six month point, at the twelve month point. You and I both know that if somebody phones you up, and you think 'oh, this is awfully negative, I'll just say no because nobody's going to check', you know. So we feel that...that's partly why we think the audit form is really going through the motions. And I think it was designed originally as ...bean-counting if you like, so that Lothian Health could say to the Scottish Exec 'oh look, these are the people who've had smoking cessation work'. It wasn't proper audit, it was just to justify the funding, and that, we feel, is certainly the wrong way of actually going about it. (LHCC Management/Strategy/Co-ordination)

Respondent R1B above discussed his/her desire for a "normal" comprehensive service, with people "earmarked" to conduct the evaluation work. R1B's perception that the monitoring process was simply "going through the motions", was shared by many respondents, who similarly questioned the usefulness of the monitoring feedback in shaping or influencing local service development or delivery. One interviewee did however reflect on the monitoring process as useful in terms of assessing how their LHCC was progressing in relation to other areas. However, in this case, interestingly the feedback did not appear to have been used in any way to shape service development and delivery:

**R3C:** It either pulls you down, because your figures aren't as good as other peoples, it gives you heart because you're better, or you think 'that's not bad' because you're the same. But it also gives

you an idea about...is the mode that we're delivering the best one. But that's why it's nice to see across the Localities, because we know how they're all- everybody's working slightly differently- so you can say 'well, we all seem to be roughly the same, but we're all using slightly different techniques, so there's obviously not a right way, you know, any of these are going to work'. And the other thing is because you want to see whether groups versus one-to-one and, of course, cost-effectiveness too, you know, one person can run a small group, two people can run a big group, but one-to-one that's very staff...rich, you know, you need a lot of staff to do that. Some of the people that are on-board are practice nurses, because they're obviously in a better position, because it's part of their job.

**Int:** So it's seeing how other people are doing and...

**R3C:** It does, it gives you an overview of the methods that work, the methods that don't work...anything that's failing...

**Int:** Have you ever changed your service according to the feedback that you've been given?

**R3C:** Not yet, because we've only been doing it for two years.  
(Service Delivery)

It was unusual for interviewees to discuss that they reflected upon the feedback to monitor the effectiveness of the smoking cessation interventions on offer within the their LHCCs. Due to their scepticism about validity of the audit data, many interviewees dismissed its usefulness in relation to their own service evaluation. Even where monitoring information was described as useful it was not deemed by respondents to influence service development or delivery in any way. Interviewee R3C, cited above, argued that it was useful to be able to compare the data for the group and one-to-one support. Some interviewees however reflected upon the potential usefulness of more detailed data, particularly relating to the success of individual GP Practices, or at the individual group level. For instance, the following extract is taken from an interview with a respondent who worked in an LHCC where the local service had a strong Practice-based component:

**R1E:** It would probably be useful for individual people, and then you could look at good practice, because as I say, although they've all been trained in the same way, they run clinics in different...you know some run them at set times, and is that a good way, are you getting a good response, or is it better to sort of go into the office and have ad-hoc [few words?] with the practice nurse. And if we did have somewhere that was doing evening sessions, whether that works better as well. So, it would allow you across [Health Board

area]- because there are various ways of working, to consider what was good practice and what was working, and I think at this stage we don't. It's really just sort of people's opinions rather than actual fact. **(LHCC Management/Strategy/Co-ordination)**

Interviewee R1E suggested that more detailed information could potentially benefit local service delivery, by indicating what was best practice in delivering smoking cessation support at the local level. Another respondent commented upon the detrimental impact of the monitoring information that was given to the LHCCs. R1A suggested that due to the inaccuracies of the audit data, it was difficult to negotiate with local GPs around local service delivery issues:

**R1A:** I haven't found it [evaluation feedback] useful in terms of providing certainly us with information about what's going on. I don't like their aggregate statistics, because they exaggerate ludicrously the level of success of the smoking cessation interventions, at least in the way that they are presented, and that doesn't help your case when you're trying to argue with GPs, who are very kind of em...you know, scientific minded. So if you start saying to them 'well we've got a 50% success rate'- 'that's nonsense, we don't'. All the kind of longer-term evidence is that if you bunk somebody some sort of em nicotine replacement therapy, there's...was it eight percent or something that is the...you know, an eight percent higher chance of stopping smoking. If you have high quality support added onto that, then you can double it to sixteen percent. So that to say that somehow locally in [Health Board] that we're getting forty or fifty percent, people are just laughing at it and thinking 'what's this, this is just mince', and it is sorry. **(LHCC Management/Strategy/Co-ordination)**

As this particular LHCC had a strong Practice-based component, the support of GPs and their practice nurses was likely to assume considerable importance. Respondent R1A, above, intimates that the monitoring outcome data mocked the smoking cessation strategy in some way. Specifically, R1A suggested that GPs were aware of an evidence-base surrounding the effectiveness of smoking cessation interventions, and therefore that the feedback data reflecting LHCC success rates was inaccurate. However, even though GPs were perceived by R1A to be aware of the evidence-base around the effectiveness of smoking cessation, the data extract above suggests that there was still a degree of tension in trying to engage with GPs regarding smoking cessation interventions. This raises an additional issue around GPs attitudes towards

the evidence-base surrounding smoking cessation interventions, and the perceived effectiveness of interventions in day-to-day practice.

Several interviewees discussed the evidence-base surrounding the effectiveness of smoking cessation interventions, and gauged their own LHCC statistics (monitoring feedback data) against these figures. Indeed, one interviewee queried the precise role of the Health Board evaluation, given the strong evidence base around the effectiveness of smoking cessation interventions:

**R1G:** Thorax has done so much over the last four years, and pulled everything together, and the research is there, and I don't...I hope that we're not kind of arrogant enough to think that what we do will actually give much more rewards than what anybody else has done. **(LHCC Management/Strategy/Co-ordination)**

Another interviewee from the same LHCC also stated:

**R2G:** We know if you're using the research base method, you know your success rates are going to be in the ballpark. **(LHCC Management/Strategy/Co-ordination)**

Given the strong evidence base that already existed for smoking cessation interventions, interviewees R1G and R2G proposed that a snapshot auditing process might be more appropriate. Rather than every smoker being followed-up, it was suggested by these interviewees that a sample of smokers be selected for the follow-up, which would consist of more thorough measures- i.e. saliva testing or CO monitoring.

Beyond simple success rates, several interviewees also argued that the monitoring procedure used by the Health Board did not capture all elements of the success of a smoking cessation intervention. Specifically, it was argued that the monitoring procedure failed to account for those patients who had significantly reduced their cigarette consumption. This was due to the measure of 'success' as being simply defined as whether the smoker had quit, or not. Additionally, it was posited that the evaluation would not reflect the progress of those patients who had moved forward through the cycle of change, but who had yet to quit. It was argued by interviewees

that there was little account taken of the work and effort that health professionals put into helping such patients:

**R1D:** They [audit forms] really don't give you a chance to reflect on what kind of input you're having in practice, you know, they're very much geared to like, you know- 'how many cigarettes were they starting with?' And, you know, zero seems to be the magical number, but you know, if you've got somebody who smokes 70 cigarettes a day, and you can get them down to 10, that's a hell of a great achievement, and you may never ever get them off the 10, but it's better that where they were. And that, from where we were sitting, was a great achievement, but it wouldn't count for anything in the evaluation forms, because it wouldn't be recognised, you wouldn't record it as somebody who had successfully stopped smoking, so it would be a failure in evaluation terms. So from that point of view, I don't think the evaluation really captures all the information that we would like it to have. **(Service Delivery)**

Respondent accounts therefore suggested that the audit forms should encompass a much broader range of measures, in order to represent the complexity of the cessation process and interventions. It was argued that this would capture the individual successes that fell between the 'quit- not quit' dichotomy, which in turn would also recognise the effort that was invested in helping such patients.

#### **7.2.4. Monitoring as 'Service Provision'**

Several interviewees commented that the monitoring process could itself become a potential resource for intervention, essentially as an extension of the smoking cessation service. Respondents intimated that the three, six, and twelve-month follow-ups were wasted opportunities for potential intervention. Specifically, it was argued that if a patient had relapsed at these time points, the monitoring procedure could be used as a potential to intervene. The three-month stage was highlighted by respondents as a particularly crucial time for quitters, given that it was when many patients would be ending their three-month course of NRT, and thus a potentially 'delicate' time in terms of relapse. The following data extract discusses the monitoring process within the context of the stages of change framework:

**R1J:** But I think it begs the question- 'what is this [monitoring] about?' If it's simply an audit then it doesn't matter who does it,



you know, you could hire anybody to sit in a call centre and make those calls. If it's a potential for intervention, recognising the readiness to change, you know, this could be an opportunity for me to catch my patients at a vulnerable time, just to do a wee bit of work over the phone. And if that was one way of actually extending the service provision, at the same time as [making?] and audit, you know, but then you've got to have the flexibility of saying 'well do you want to come and see me?'. So we need to be asking ourselves the question 'what is this about?'. So we need to be asking ourselves the question 'what is this about?'. If it's simply audit then I don't think it matters who asks the question. If it's a potential for intervention then I think arguably the three months could be seen as a ...that vulnerable time when the patches just finished, maybe the Zyban user's been off for a month and they've been struggling. It could arguably be another possibility of, you know, intervening, and using it primarily as an audit response, but...'so how's it going, you know, what's been making it difficult, have you thought about, you know...would you like to be referred back in again?'...that sort of thing. **(Service Delivery)**

The above data extract highlights the perceived potential for the monitoring process to tap into the patient's 'readiness to change' cycle. The respondent suggests a potential for intervention if patients have entered the relapse stage, or when the safety net of pharmacological support is removed. Respondent R1J also raises the issue around who would be involved in conducting the follow-up. S/he suggested that an extended monitoring process would allow him/her to follow-up his/her own patients and re-refer them for smoking cessation support if required. In the following data extract, respondent R1B discusses the potential benefit of the original smoking cessation support provider conducting the follow-ups beyond the one-month stage:

**R1B:** There's a trust if you like there, being developed between the provider and the individual, and yeah I think that should be [health professional following up the patient rather than Health Board]- and I think it should probably happen at six and twelve months, you know, because it is important that the individuals then say 'this person, this health professional's taking an interest in me', you know, 'they are interested', rather than getting a piece of paper through the post, or a phonecall. **(LHCC Management/Strategy/Co-ordination)**

R1B went on to suggest that smoking cessation support providers might be more successful in identifying with patients if they had relapsed, and in referring them on for appropriate support:

**R1B:** I'm not clear where they [Health Board] actually go if an individual says 'well, I was smoking 60, I then stopped following the smoking cessation, but now at the three-month point I'm smoking 60 again'. What does [Health Board] do at that stage? Do they say to the person 'oh, go back to your GP, start the cycle again'. Whereas if the individual who provided the support in the first...time...could actually identify with that. (LHCC Management/Strategy/Co-ordination)

Although several interviewees perceived the monitoring process/follow-ups to be a potentially useful method of intervention, this also raises the question of the time that would be involved in conducting more intensive follow-ups. The time-consuming nature of the one-month follow-up process was discussed previously in this chapter. It is possible, therefore, that additional monitoring/intervention responsibilities could be perceived by some health professionals as putting pressure on already demanding workloads.

Section 7.2. has focussed on four aspects of the monitoring/evaluation process adopted by the Health Board. Many interviewees perceived the monitoring process to be very time-consuming, and respondents highlighted inconsistencies in how the one-month follow-up in particular was conducted. Additionally, interviewees discussed their perceptions around the perceived efficiency and value of the Health Board feedback. Here there appeared to be discontent with the accuracy and 'timeliness' of the feedback. Frustration with the quality of the Health Board monitoring process, and a lack of confidence in the comprehensiveness of the process, seemed to engender a notion that auditing was a meaningless exercise. Finally, it was posited that the monitoring process should be regarded as a potential for intervention, as opposed to simply being a number-crunching exercise.

### **7.3. Chapter Summary**

Interviewees clearly located the smoking cessation strategy within a broader political framework. Two key, but inter-related, issues underpinned discussion around the ‘place’ of smoking cessation on the national agenda. The first issue related to the level of funding that was assigned for the development of services. The second issue related to where interviewees perceived smoking cessation to sit as a priority in relation to other health issues/strategies. There was a general consensus among respondents that smoking cessation warranted greater financial investment. Respondents expressed frustration because of inadequate funding for the development of services that were sustainable, and could meet the needs of the three priority groups. Discussion around the Health Board monitoring/evaluation process also highlighted the importance of implementing a monitoring/evaluation procedure that is perceived as valuable by those health professionals providing the service.

# CHAPTER EIGHT

## Interventions

This chapter discusses interviewees' perceptions of, and attitudes towards, certain aspects of the smoking cessation interventions. In doing so, the chapter addresses important issues relating the perceived capacity and suitability of primary care as a setting for smoking cessation interventions, wider ethical and theoretical frameworks informing service provision, and key issues around service delivery. The format of the chapter is as follows:

- 8.1.** Brief interventions and pharmacological support
- 8.2.** Motivational Approach
- 8.3.** Prioritisation and targeting
- 8.4.** Smoking cessation and the primary care setting
- 8.5.** Smokers and addiction
- 8.6.** Chapter Summary

### **8.1. Brief interventions and pharmacological support**

This section addresses two key areas. Firstly, it discusses interviewees' perceptions of the brief intervention process. Whereas chapter five discussed the role of NRT/Zyban as catalysts for service development, section 8.1 of this chapter incorporates discussion around the role of NRT (Nicotine Replacement Therapy) and Zyban in the brief intervention process. The section then moves on to discuss the motivational, ethical, and financial considerations that interviewees raised around NRT.

#### **8.1.1. Brief Interventions**

To reiterate, the brief intervention process recommended in *Thorax* (Raw, McNeill & West, 1998a) involved five key steps: *Ask, Assess, Advise, Assist, and Arrange*. On

contact with patients, therefore, health professionals would *ask* about and record their patient's smoking status at every opportunity, *assess* interest in quitting, highlight the dangers of continued smoking and *advise* them on the benefits of quitting. Subsequently, if a smoker should wish to quit, the health professional would *assist* the smoker in doing so. This would involve working with the patient to set a quit date, and referring them to intensive smoking cessation support services where appropriate.

As was discussed in chapter five (Service development and LHCC Capacity), GPs were described by respondents as the main providers of brief intervention support within the LHCCs. It was these GP interventions that interviewees tended to comment upon in the interviews, rather than those provided by other health professionals. However, there were reported variations in the efficiency and effectiveness by which these brief interventions were carried out. One of the main problems interviewees raised was a perceived lack of attention given to the motivational status of the patient by GPs. In particular, respondents referred to the assessment of patients' readiness to quit. For instance, respondent R1B below discussed that many GPs did not effectively follow-through with the brief interventions in patient consultations. This was perceived to be particularly the case for those GPs who had not undertaken the smoking cessation training:

**R1B:** We certainly feel that for a lot of the GPs who have not done the brief intervention course, the brief intervention possibly consists of- part of a normal consultation- 'Mr Smith, nice to see you today, what's the problem, I actually think you should stop smoking. We run a smoking cessation service, would you like...?'- 'yes, thank you Doctor'. And they go out the door, and that's the brief intervention. And that is not what brief intervention's about. Brief intervention is about seeing if the individual is properly motivated, and ready to go, and ready to start- we want that individual to say 'I want to stop', not as part of a normal consultation. Brief intervention probably takes 15 or 20 minutes, to actually sit down and talk with the individual. GPs don't have time for that. (LHCC Management/Strategy/Coordination)

Respondent R1B proposed that due to time constraints within the consultation, GPs were unable to conduct brief interventions effectively. Consequently, s/he posited that patients could be inappropriately referred for specialist support:

**R1B:** So we feel the intervention is largely by-passed- it has been largely by-passed. And individuals aren't...patients or clients when they're referred to us, possibly aren't motivated, or self-motivated to stop- for the vast majority. The minority, or a number obviously are, and those are the ones that continue to attend.  
**(LHCC Management/Strategy/Co-ordination)**

Due to the perceived inappropriate (or lack of) assessment of motivation and inappropriate referrals by GPs, it was discussed that patients had to be 'filtered out' at a later stage by the health professionals providing the intensive support. Several interviewees argued that if more work was done by the GP at the brief intervention stage (e.g. through extended appointments or more thorough questioning), this would (a) ensure that patients were adequately motivated, and (b) lessen the burden on the next person in the referral chain. The following extract is from a health professional who intimated that patients referred onto him/her for specialist support were not always at the stage of being ready to quit:

**R1J:** The GP could possibly have done a bit more work prior to referral, and that work might have actually realised...no, this patient isn't ready. And what would be wrong with the GP saying 'look, take away the book [smoking cessation book], give it some thought, and come back and see me', rather than referring them onto me, and then six weeks later I see them and say 'look take away the book, and go back to your GP'. **(Service Delivery)**

Although guidelines were issued to healthcare professionals around providing brief interventions, there was a perception that adherence to these guidelines was not always systematic, or uniform. Indeed, it was recognised that there was considerable variation amongst GPs in terms of how they were perceived to adhere to the principles underlying the brief intervention and referral process. The following extract describes the experiences of one interviewee, who described how s/he had questioned his/her *own* GP about the use of the smoking cessation guidelines within the context of a medical consultation:



**R11:** And I went to see my GP, and I said to her, [LHCC name], I live in [LHCC name], so I went to her- and she knows what I do- and she had her chart up, and she said 'all these people want to stop smoking', list all charted up, and I said to her 'we'd done national guidelines, cessation guidelines about, you've maybe seen them, I don't know, there are ones for GPs so that they can do brief intervention- so if I came in, *do you smoke, do you want to stop-no, I'm thinking about it*, the GP would mark that and say, and ask the next time, so this is...'. And I said to her, and she says 'no, I'm not using the guidelines, why would I do that?'. (**Advisory Group**)

The above data extract highlights one GP's perceived lack of awareness around, and willingness to engage in, providing smoking cessation interventions. Respondent R11 went on to discuss the 'implementation gap' around smoking cessation guideline adherence. As the extract below indicates, this was attributed by R11 to a lack of awareness amongst GPs of the evidence base surrounding the effectiveness of brief interventions:

**R11:** And so you see, even though you do all this good work, actually getting it done on the ground is really getting jammed. And then she had, there was a GP that had the ability with this document [smoking cessation guidelines] to intervene, to refer, and she's putting people up on lists because she just thought 'well it's a cessation service, they'll just have to wait'. She didn't see how important it was that she could have kept those people motivated- she could have intervened in a brief intervention, you know, 'this would help you enormously', and that would have been very effective. She didn't do any of that. So we've got a lot of work to do around that. (**Advisory Group**)

With regards to the evidence base for smoking cessation interventions, there was also a perceived lack of attention amongst service providers to the evidence base surrounding the link between Zyban and intensive support. The evidence and guidelines for the role of Zyban in smoking cessation stipulated that it should be prescribed only with intensive support. However, as highlighted by several health professionals, the guidelines were not always necessarily adhered to. In the following data extract, one health professional reflects upon on the responsibility that GPs had for ensuring that those patients who were prescribed Zyban were also willing to

receive intensive support. However, this health professional posited that patients who had been prescribed Zyban did not always subsequently approach him/her for specialist support:

**R4E:** Em, at the moment, what has been happening with the GPs, that they [patients] go to the doctor- and it's happened with two different...young women actually, who go to the doctor, get their prescriptions for Zyban, and then never, I never see them [for specialist support]. I follow them up- they (one word) the records through to me, make arrangements to see them, but they don't come in. So I'm sort of not, I can't say whether they've had the Zyban, and they've given up completely on their own, which sounds fine if they do that, but I'm also not- I don't know whether they've had the prescription, but never actually [one/two words], and never actually followed it up, in which case it's a waste of a prescription really. I think sometimes it's useful to just make sure that they are actually going to use it, and going to follow through with it, rather than just writing a prescription because they ask for it. **(Service Delivery)**

There was not only concern that this was happening with Zyban however, but also with NRT. For instance, one health professional (respondent R2F) agreed with the above respondent's perceptions about Zyban, and also claimed that many GPs were acting similarly with regard to NRT. In particular, R2F argued that there was reluctance amongst GPs (and pharmacists) to administer intensive support alongside NRT:

**Int:** Initially when the groups- it was just the zyban that wasn't always being prescribed without specialist support, or was it the same for NRT at that stage as well?

**R2F:** My memory, if my memory serves me right, the zyban became available on prescription before the NRT, so in fact the thing [guidelines] was set up for the Zyban. But then NRT was tagged on when it became available on prescription. But there was much more resistance from GPs, as I say this largely was led by the pharmacists, primary care pharmacists, there was a lot more resistance by GPs to this idea that NRT should be tagged on to this as well. And I suspect that most GPs have just ignored that, and done their own thing one way or another. **(LHCC Management/Strategy/Co-ordination)**

Zyban was available on prescription for a year (July 2000) before NRT followed suit (June 2001). The above extract (R2F) indicates that there was more perceived resistance to administering/recommending intensive support alongside NRT than there was with Zyban. Although not elaborated upon by interviewees, this may be attributable to the possibility that NRT was seen as a relatively 'safe' drug (as an over-the-counter medication) compared to Zyban. It may not therefore have been perceived by GPS as requiring the same level of additional patient support/monitoring.

There was also concern that NRT could be viewed in isolation, as a 'one-stop-shop' smoking cessation intervention. For instance, one health professional (R2A) expressed concern that GPs may just prescribe NRT at a consultation, without even brief intervention support. When considering the provision of smoking cessation support within his/her Practice, R2A intimated that if the intensive one-to-one support ceased to be funded, then patients would simply be administered NRT without any other form of support. As the extract indicates, R2A attributed this to the emphasis and importance that GPs tended to place on *prescribing* within consultations:

**R2A:** I think if the Doctors had- if the Doctors had their way, they would take my time away...there's other [one word?] they can do.

**Int:** ok, so it [intensive smoking cessation support] would have to be done in your own time, at night, or...

**R2A:** Aye. But I mean I think- it's a shame because not everybody wants to go to a group, and in fact a lot of people don't want to go to groups. So it's nice for them to be able to be given the time to discuss NRT and discuss other things about their smoking, and give them the help there (in the consultation). But that's not often seen as being valuable, when you can write a script out. **(Service Delivery)**

There were therefore strong concerns expressed about the effectiveness of brief interventions provided by GPs. What is clear from discussions thus far is that there was a perceived lack of understanding/awareness - or simply *adherence* - to the evidence-base around smoking cessation interventions. Given that GPs acted as the primary referral source, discussion around these issues tended to be concentrated on

the actions of this profession. There were three perceived consequences of ineffective brief interventions. First, patients' readiness to quit was not properly assessed at the brief intervention stage, and therefore patients may be inadequately referred-on for specialist support. Second, patients were simply offered a brief intervention and NRT, without being referred-on when appropriate. Third, there was concern that GPs were simply prescribing pharmacological aids (NRT in particular) without additional support.

### **8.1.2. NRT- Motivation and ethical & financial considerations**

Interviewees tended not to challenge the evidence base surrounding the role of NRT in smoking cessation. There appeared to be a general acceptance that NRT had an additional impact on cessation rates over and above the effects of general advice alone. However, there were two main areas of contention with regard to NRT. One was the link between NRT and motivation. The second was the ethical and financial considerations around prescribing costs.

There was a degree of controversy around the prescribing of NRT without adequate assessment of a patient's motivation to quit smoking. This issue was prominent in early discussions around the development of services within the Health Board area, when NRT was not yet available on prescription. There were two particular schools of thought about how NRT should be issued. On the one hand, some Advisory Group members proposed that patients should not receive free NRT until they had demonstrated motivation to quit. On the other hand, there were other Advisory Group members who were of the opinion that *not* issuing free NRT would act as a barrier to quitting in the early stages of the cessation process:

**R2I:** There was the sort of more theoretical- almost moral discussions- about the issue of getting it [NRT] free, and when they should get it free, part of it, and some people said 'oh they should pay for the first one, and come back and get it free when they've shown the commitment'. And other people were saying 'oh that's putting a hurdle in people's way'. It was almost a conflict of approach, you know. Some people would say, you know, 'we have the opportunity to lay the door open, and not put barriers in people's way'. Other people would say 'no we need to put a barrier to check people's commitment, so we're not wasting

money'- the idea that if you just gave it free to everybody on the first visit they'd never come back, you know, they'd just take it for the first week, and we'd waste- potentially waste- a limited amount of money. **(Advisory Group)**

Respondent R2I also commented on professional opinions. Specifically, s/he highlighted the perceived views of pharmacists around issuing free NRT to patients when there was no guarantee of their motivation to quit smoking:

**R2I:** And I did meet some opinions from pharmacists who were quite different to what I'd expected- they were very cynical...I suppose from their experience of smokers going in to buy NRT, that they...the usual experience of people coming in and maybe buying a weeks worth, and they never come back- because previously people weren't given any extra...support. **(Advisory Group)**

Respondent R2I later pointed out, however, that this view appeared to change as pharmacists became more involved in the delivery of the smoking cessation services, and undertook training. Interviewees also proposed that when NRT became available on prescription, this helped to solve many of the conflicts of issuing free NRT. That is, the provision of a formal framework within which NRT could be provided free, helped to diffuse the arguments around patient motivation and resource limitations outlined above. Essentially, prescribing guidelines would establish who received free NRT. In most cases LHCCs adopted a 3-month prescription format, whereby NRT could be issued on prescription for a period of three months.

As was discussed in the previous section, there were perceived variations in the quality of brief interventions, and concern that patients could be prescribed NRT or Zyban without appropriate motivational interventions. One interviewee who provided intensive smoking cessation support had strong views around the over-reliance on pharmaceutical interventions. S/he argued that NRT/Zyban could undermine the role of patient motivation in the cessation process:

**R1J:** My gut feeling is, as a practitioner, that I want a sense of where this person is before and prepare to negotiate a prescription. And that's not about saying 'well you can't have one 'til you've convinced me', but the message I want to put across when a patient

comes is quitting smoking isn't something that you rely on a prescription for. **(Service Delivery)**

R1J went on to add:

**R1J:** My message on week one is 'lets look at why you're here, why are you here, why do you want to stop, what do you think's going to help you, what do you think's going to get in the way, lets look at some of the options, one of which is a prescription' - so it's actually couched in a much more general sense. **(Service Delivery)**

Respondent R1J was therefore keen to underplay the role of NRT as the 'obvious' choice for patients. However, for other health professionals NRT appeared to play more of a central role in the 'doctor/health professional'-patient relationship:

**R3B:** But it's difficult to become involved as a health professional without the carrot of your nicotine replacement. I'm the first one to say that's only a part of it, you know, there's loads of other issues that people need to consider when they want to change such a long-standing behaviour. But it does give you, in a way, the "raison d'être" to be involved- 'there is a little bit of the Medical Model I can offer you for this complex behaviour'. **(Service Delivery)**

For the above respondent (R3B), NRT was perceived as a form of currency for 'allowing' the health professional to become involved in helping patients to quit smoking. The data extract above suggests that there may also be an *expectation* by a patient for a prescription/drug from a health professional. Additionally, R3B argued that it was difficult to get involved in a patient's quitting process without NRT. Together, this suggests that smoking cessation could be perceived as a medicalised problem (i.e. requiring 'medical' intervention such as NRT/Zyban), amongst both patients *and* health professionals.

There were also ethical and financial arguments around the provision of NRT on the NHS. For instance, there were questions raised around how often patients should be prescribed courses of NRT. Additionally, some interviewees discussed whether patients should pay for their own NRT with the savings they made from quitting smoking. Concern around containing the LHCC prescribing budget was an issue that appeared to be very much at the fore within one LHCC in particular, which was



clearly evident from the interviews with staff. One interviewee from this LHCC (respondent R2F) discussed the LHCC's limited drug budget, and how there should be clearer guidelines about prescribing on the NHS. Specifically, s/he argued that it was not possible to always meet patient requirements with regard to NRT provision due to local drug budgets that limited prescribing potential. Respondent R2F described the financial and moral arguments around NRT being available on prescription:

**R2F:** But again, there's a problem there, because how often can we afford to prescribe nicotine replacement on the NHS? I mean again the policy in this LHCC, the official policy is to prescribe one course, em...and certainly not more than annually. And do they make exceptions to that? People have been successful in stopping with the nicotine replacement, but they have a set-back a few months later and they come back wanting more. Em...now who's decision should that be? Nicotine Replacement's available on prescription. Now that's a difficult one. I feel, personally, that it would be much better to have put the funding for NRT on prescription into smoking cessation services, and let people who could afford it, and perhaps have exceptions, you know, to the...or allow an initial prescription to get over the problem of cost for people when starting off. **(LHCC Management/Strategy/Co-ordination)**

Respondent R2F went on to argue that the savings patients made from quitting smoking should fund their NRT:

**R2F:** But then I think they should only get their first prescription, you know what I think, they should only get their first prescription on, first NRT on prescription, then they should be asked to buy it, because the saving they're making on not smoking should pay for the nicotine replacement, I would think. **(LHCC Management/Strategy/Co-ordination)**

Whereas respondent R2F argued that patients should buy their NRT from the saving they made from quitting smoking, one interviewee (from another LHCC) who worked closely with low-income patients had a quite different perception of this issue:

**R1G:** There were some issues at that time (before NRT went on prescription) spoken about 'well if folk stopped for a week they can

save their fag money and buy their patches after that', but in reality...I done an audit of my clients about a year after... a year into the White Paper, 'n out of 15 clients I'd seen...new clients I'd seen in a week, 12 of them bought their tobacco from black market sources or non...you know...they were paying £7-£12 a week, rather than twenty quid for patches. And I also found it quite difficult to persuade somebody to take a gamble on something that was 84% ineffective...do you know what I mean? (**Service Delivery**)

Respondent R1G contended that the notion of encouraging patients to buy their own NRT from the savings they made from quitting smoking was too simplistic. In the data extract above, R1G couches this issue within the context of people's lives, and patients' social/material circumstances. Additionally, this respondent highlights the additional difficulty of persuading patients to pay for a drug that they perceived to have limited effectiveness.

This section (8.1.) has discussed the issue of patient motivational assessment, within the context of both brief interventions and the prescribing of NRT. The following section moves on to consider the issue of patient motivation in more depth, and its impact on service development and delivery.

## **8.2. Motivational Approach**

The provision of smoking cessation support that met the varying motivational needs of smokers (brief interventions to specialist support) was one of the key principles of the NHS smoking cessation strategy, as outlined in the *Thorax* guidelines (Raw, McNeill, & West, 1998a). In discussions around the delivery of local services, interviewees highlighted various issues around service compatibility with patient motivation and the different stages of change in the smoking cessation cycle. To reiterate, 'Stages of Change' refers to the stage-based model of behaviour change that depicts an individual as progressing through five stages. These five stages include: 'pre-contemplation' (i.e. not considering quitting smoking); 'contemplation' (i.e. considering quitting smoking); 'preparation' (i.e. ready to quit smoking and making clear plans for behaviour change); 'action' (i.e. quitting smoking); and 'maintenance' (i.e. stopped smoking and remained abstinent for 6 months).

One issue highlighted by a few interviewees related to service structure, and the impact this might have on patient motivation. An aspect of this structure, raised by interviewees, was the waiting lists that often existed for the provision of intensive smoking cessation support. It was argued that in order for patients to maintain their level of motivation, it was essential that they were seen quickly by a health professional for this support. In discussing their local LHCC service, one respondent raised the issue of the need for a quick and efficient referral process:

**RIA:** It [intensive smoking cessation support] should be available to you without a horrendous wait of time, you know, it shouldn't be 'yeah, you can have that, but you can have it in...it'll be nine months before we can fit you in and see you', particularly given that the chances of somebody stopping smoking are quite strongly linked to their level of motivation. So if their level of motivation is assessed as high, and then you say 'that's fine, but the group doesn't start until, you know, July 2005', their level of- it might still be high- but who knows where their level of motivation's going to be. It's something that needs to be...it needs to have a pretty immediate response". (**LHCC Management/Strategy/Coordination**)

The interviewee cited in the above extract worked within an LHCC that had opted for a practice-based approach to smoking cessation. Service development and delivery was not therefore centrally co-ordinated or managed. As discussed in chapter five (Service Development and LHCC Capacity) there was a lack of knowledge around the extent of local practice-based service development. However, there was not perceived to be a comprehensive development of services within the LHCCs. The above discussion around waiting times may, therefore, have been couched within the context of a perceived lack of comprehensive service development and management. A respondent from another LHCC reiterated this link between waiting lists and patient motivation (although in this case, less than effective service delivery was attributed to a lack of funding):

**R1B:** We [LHCC] would love to have two evening clinics running, or [few words] in the day, so that people can fit in as soon as possible. Because as soon as somebody says 'I'm motivated, I've done brief intervention, I'm ready to stop smoking', we really

should be giving it there and then. Giving it two months later, it really isn't much good, you know, they've either stopped smoking, they've had the baby, or they're no longer interested, and we have then perhaps to go through the whole brief intervention things again. Again it comes back to the funding issue. I'm sorry to harp on about the funding, but it really is...it really is the main issue.  
**(LHCC Management/Strategy/Co-ordination)**

The problem of waiting lists was one that was echoed by interviewees across several LHCCs. However, a formal system for managing waiting lists based on motivational assessment was established within three LHCCs ('C', 'F' and 'D'). As will be discussed, these systems were underpinned by the concept of patient motivation. Interviewees discussed the perceived need for such systems, as a means of managing lengthy waiting lists, and identifying appropriate patients for intensive support. An outline of the systems used in each of these LHCCs is provided in Table 3, which indicates the process of referral management, from the stage of GP referral, to the identification of patients for intensive support. As can be seen from Table 3, the method employed varied. However, each system was designed to 'filter-out' those smokers perceived to be the least motivated to quit.

Respondents from the LHCCs highlighted in Table 3 discussed the value in motivationally assessing patients for their readiness for intensive smoking cessation support. To reiterate, one of the key perceived benefits was in filtering-out the less motivated smokers. For instance, one health professional from LHCC 'C' discussed the benefits of the screening process adopted within his/her LHCC. Specifically, s/he described the motivational interview as an effective means of reducing waiting lists, and allowing motivated patients to access support more quickly:

**R2C:** I think it's [motivational interview] essential. Em, I don't know how people, I know other areas [LHCCs] don't do them, but it's a way of just sussing out just how, how motivated, you know, that's what it's all about, you have people who have just said 'oh yes I want to stop smoking because my GP has suggested it', but they don't turn up to the interview. But sometimes they do, and they say, 'well it's really not the right time for me, I just said yeah, but it isn't the right time'. So you can start weeding people out.  
**(LHCC Management/Strategy/Co-ordination)**

**Table 3. Management of waiting lists and assessment of patient motivation in LHCCs ‘C’, ‘F’, and ‘D’**

<b>LHCC</b>	<b>Referral Management Process</b>
<b>C</b>	<ol style="list-style-type: none"> <li>1. GP referrals sent to LHCC co-ordinator and central database</li> <li>2. 50 letters sent to patients informing of next group of intensive support sessions, and inviting them for motivational interview (approx. 20mins with healthcare co-ordinator/nurse- assesses motivation and suitability for groups or one-to-one support)</li> <li>3. Patients have one of 3 choices: respond and attend interview; respond and ask to be kept on waiting list; on not respond and be put to bottom of waiting list.</li> <li>4. At motivational interview patients are assessed for suitability for either group or one-to-one support.</li> </ol>
<b>F</b>	<ol style="list-style-type: none"> <li>1. GP gives patient a self-complete form at consultation. Patient’s responsibility to complete and send back to central LHCC smoking cessation co-ordinator.</li> <li>2. 50 people from list invited to attend an information evening</li> <li>3. Those who do not attend are sent a letter and asked if they wish to remain on waiting list. Those who do not respond are taken off list.</li> <li>4. Those who <i>do</i> attend are assigned to a group for intensive support.</li> </ol>
<b>D</b>	<ol style="list-style-type: none"> <li>1. Patients referred by their GPs to central smoking cessation co-ordinator</li> <li>2. Within 2 weeks patients sent a letter to say they are on waiting list, and given an information sheet about the LHCC service. Patients also asked to complete a self-assessment questionnaire about smoking history, readiness to quit, previous quit attempts, and thoughts around potential NRT / Zyban use.</li> <li>3. Patients informed that if they do not reply within three months then their name will be removed from database.</li> <li>4. If patients do not respond, the referral form is sent back to their GP.</li> </ol>

The previous data extract (R2C) highlights one of the key issues raised in section 8.1. of this chapter, around the role of the GP in the brief intervention process. That is, there was a perception amongst interviewees that brief interventions were not always followed-through effectively by GPs. Consequently, issues were raised around inadequate assessment of patient motivation. Interviewees did not explicitly make a link between inadequate brief interventions and the motivational screening process adopted by LHCCs. However, there was clearly perceived to be a need for a more rigorous screening process than the brief interventions provided. One interviewee

from LHCC 'F' discusses below why information evenings were used to screen smokers:

**RIF:** But one thing that happened that was actually...I think one of the best things that we did...and I picked this up from going down to the Maudsley training on smoking cessation. I was lucky enough to be sponsored to go down and do that. And they say that...yeah, they have huge numbers referred to them as well, but the way they cope with it is to run information evenings and see who turns up. And the motivated people are the people who are going to turn up. And out of that- the information evening- they can then find out people who are core. So really, it's just chopping back to the most motivated people. **(LHCC Management/Strategy/Co-ordination)**

RIF suggests in the above data extract that the motivational screening process identified the most motivated smokers. Indeed, there was a perception amongst several respondents who discussed the benefits of the motivational screening process that those patients who did not succeed in this process were simply less motivated. However, there was limited discussion by these respondents around the factors affecting patient attendance at information evenings *other than* motivation (e.g. transport/access; working patterns; family commitments). RIF went on to discuss the smoking cessation success rates for the LHCC. S/he argued that these rates were higher than average given that the motivational screening process identified the most motivated smokers:

**RIF:** I think the last figures we got, it was something like...46% or something...success- at a year. Now this is quite high, because they reckon that the highest you could probably get would be between 20 and 30%. But I mean we're not the highest in the locality at all. But I think it's because we're not just taking just any old Joe Bloggs in, and trying to get them to stop smoking. **(Service Delivery)**

The motivational screening approach used in this LHCC, and LHCCs 'C' and 'D', which had formal systems of screening patients, represented a relatively high threshold service. This was a consequence of the focus on identifying the most motivated smokers. However, the motivational screening approach contrasted quite sharply with the approach to service delivery adopted in LHCC 'G', whereby a *low*



threshold service was embraced. Within LHCC 'G' the Maudsley research and evidence base was also drawn upon. However, this affected service development and delivery in a quite different way. The following extract demonstrates the contrast in approach and philosophy:

**R1G:** So I would say that our success rate may be lower, because we are reaching groups, you know...a lot of smoking's based on the Maudsley research, which was, you know, pre-nicotine replacement, a lot of people came along twice before they started treatment. So you had two chances to opt out....

**R2G:** You'd filtered out the people who weren't really motivated...

**R1G:**...and very clear about stopping and, you know...and I think probably really useful, you know. But my remit's to get folk into services, and low-income groups, and...[few words?]. I believe smoking cessation should be as easy to access as going to buy a packet of fags. **(R1G & R2G: LHCC Management/Strategy/Coordination)**

This LHCC favoured a low threshold service, contrasting sharply with the motivational screening approach used in LHCCs 'C', 'D' and 'F'. LHCC 'G' was also committed to targeting low-income groups. As the above extract highlighted, having a low threshold service was perceived as key to achieving this. Although, it was recognised by respondents in LHCC 'G' that success rates may be relatively lower than other LHCCs as a result.

A few interviewees also discussed the challenge of reaching those smokers that were 'pre-contemplative' and not motivated to quit smoking. It was perceived by such respondents that the NHS smoking cessation strategy was limited in this regard:

**R1J:** And I think a lot more pre-work needs to be done to even encourage people into the service. Now if you then add on to that that you've got a service that can't cope already, the motivated people that are coming along, how on earth are they going to get the unmotivated, highly addicted smokers? And that's the challenge, we haven't cracked that, we're still at the easy end of it, I think, you know, where people are putting their name down, are people that, you know, have been contemplating it and thinking about it, and moving it forward. **(Service Delivery)**

Interviewees also discussed the issue of patient motivation within the context of the structure of service delivery. The broad framework of service delivery outlined in the smoking cessation guidelines involved the provision of brief interventions and, if required, the follow-up of intensive one-to-one/group support for a period of 6 weeks. Several interviewees however described this format as too rigid, and incompatible with patients' motivational processes, and the process of cessation more generally. In particular, there was concern around the lack of support on offer to patients *after* they completed their intensive support, and had effectively 'left the system'. Several interviewees raised the issue of relapse, and the need to have a flexible service in place to accommodate this:

**R2B:** My background's in community development and you know, we should do our best to meet the needs of the participants, you know, you can't develop a service, like a smoking cessation service, and say 'everybody will just have their 6 weeks', you know. I find it quite crazy the whole way...the way it's all been set-up. And we're trying to respond to need now in the way that we're extending groups, if that's what the participants want, and hopefully the same will happen in the individual sessions as well. I don't know if the Health Visitors are doing it, I have to say, I really don't know if they're extending their group work or the individual work- they don't really do groups- but the individual work. And the thing is as well with the individual work, is people may be...perhaps have their 6 weeks, and then, you know, a month later something happens in their life that they then maybe start smoking again. Well they need to be fast-tracked back to see the smoking cessation support person, but there's nothing really. We don't have anything in place to do that- to fast track people, which we need to do. (LHCC Management/Strategy/Co-ordination)

Respondent R2B above argued that a flexible service structure would accommodate the needs of smokers more effectively, in terms of supporting them through the cessation process. S/he went on to discuss how additional funding might facilitate service development in this respect. One LHCC (LHCC 'D') had established a service structure from the outset that provided patients with twelve weeks of intensive support as opposed to the standard six weeks. In this LHCC most patients were offered four-six consecutive weeks of one-to-one/group support, followed by three or four fortnightly sessions. Additional group support was also offered at 16

weeks if required. One health professional who provided group support for this LHCC, described the benefits of such an approach:

**R1J:** So you're looking at, in total, twelve weeks of support, and what I like about that is that patients when they leave the group [at 6 weeks] are still using the prescription, so [one/two words?] vulnerable psychological time, when the prescription's ended with zyban, or the gum drops down a dose, but at that point we've lost them. And if patients aren't sure- I mean their self-efficacy isn't strong or whatever- you know, I wouldn't be surprised if patients slip at these vulnerable times. And a lot of it's psychological, but I think to know that you can come back in a couple of weeks time, when your patch dose has just been dropped, can be hugely valuable. **(Service Delivery)**

R1J went on to add:

**R1J:** But what I like about it [12 week support provision] is that it actually recognises the whole readiness to change model that says well the patient might relapse, and if they do and they're still in a group, they can actually venture back in and say what went wrong. And you're recognising this is a long-term behavioural issue that isn't going to be sorted in six weeks. **(Service Delivery)**

Interviewee R1J cited above had previous experience of using the Stages of Change model in his/her nursing career. Clearly, s/he argued that extended support beyond six weeks was a key step in recognising the realities of the behaviour change process. Indeed, many interviewees reflected on the need for some form of maintenance support following the standard six weeks (or twelve weeks in LHCC 'D') of intensive support. In particular, the critical period of three-six months after a quit date was recognised as being a vulnerable time for patients:

**R3C:** The drop-off seems to happen between three and six months. That seems to be the critical time. You start thinking about what happens at the end of three to six months. So one of the things that...slight things that would have an effect, is that we warn people, and say, you know, 'don't get over...' - and this is where some people do- they get confident, they've been off it for three months. Because every smoker wants to be the type of smoker that doesn't smoke at all, but goes out after a meal and thinks 'oh I'll have one after a meal. **(Service Delivery)**

Respondent R3C later added:

**R3C:** It's also round about the time they stop their Zyban and their NRT. So, you know, the networks and things like that are dropping back. **(Service Delivery)**

Several interviewees providing intensive smoking cessation support within various LHCCs commented on patient anxiety around the time that the groups/one-to-one support finished. In some cases health professionals providing intensive support tried to encourage patients to set-up informal feedback sessions on their own accord, in order to continue the motivational support. Several interviewees argued that it was important to build on the investment made in patients through intensive support in order to sustain the progress which they had achieved. However, resourcing this additional support was perceived to be a significant stumbling block. The issue of funding was addressed thoroughly in chapter seven (strategy interpretation). However, although there was recognition that many patients may require additional support, this was couched in a framework of how long support *should* and *could* actually be provided in practice.

In essence, interviewees appeared to have quite a clear grasp of the issue of patient motivation, and how the smoking cessation services should develop in order to meet patients' needs more effectively. In particular, there was a recognition that patients may require a more flexible service, and support beyond the 'standard six weeks'. Additionally, the concept of motivation underpinned discussions around high threshold (motivational screening) and low threshold services.

### **8.3. Prioritisation and Targeting**

The White Paper *Smoking Kills* stipulated that three groups of smokers should be prioritised for the smoking cessation services. These groups comprised young people, pregnant women, and low-income smokers. There appeared to be little direct targeting taking place using the White Paper money that had been allocated for the development of local services. Although, as discussed in chapter five (Service Development and LHCC Capacity), LHCC 'G' was progressive in developing

services that met the needs of the three priority groups. Chapter seven (Strategy Interpretation) highlighted that lack of funding was perceived to be a key factor inhibiting the development of smoking cessation services to target the three priority groups. However, *attitudes* towards ‘prioritisation’ was also a key factor, which will now be discussed.

Some interviewees expressed concern about the concept of targeting specific groups. They argued that the smoking cessation service should be equally ‘open’ to any smoker that was motivated to quit. That is, ‘smoking’ was perceived as the priority issue, with prioritisation of any ‘target group’ as a secondary aim. The following data extract is taken from an interview with a health professional, who was commenting on the smoking cessation strategy applied within his/her practice. As the data extract below suggests, this health professional (and the Practice s/he worked within) perceived *all* smokers to be a priority, within the broader framework of disease management:

**Int:** The White Paper highlighted three target groups- pregnant women, young people, and low-income groups. Has the service been developed to specifically meet those target groups in any way?

**R3E1:** I don’t...I don’t think specifically. I mean really we’ve targeted everybody we can. You know we haven’t been selective-choosing young people, selective- choosing another group. You know we see it as a priority for health promotion, and disease management, so everybody who smokes is important to us. (Service Delivery)

Respondents also raised the issue of pregnant women being one of the target groups for smoking cessation. Some practitioners disagreed with singling women out because they were pregnant. The following extract illustrates one practitioner’s account of treating pregnant women as ‘special cases’ with regards to smoking cessation:

**R4D:** I don’t think that she should be singled out because she’s pregnant. I mean we don’t look at pregnancy as ill health, so why should we exclude her from normal environments where people are coming along that are smokers, you know. (Service Delivery)

Linked to the issue of ‘singling-out’ pregnant women, was concern around victim blaming, with the emphasis placed on the potential harm to the unborn baby. Respondent R11, cited in the data extract below, discussed the intrusion that pregnant women may feel when targeted for smoking cessation. R11 was talking about women from low-income groups, although it was a view that was expressed by interviewees, about pregnant women, more generally:

**R11:** A lot of the women that we work with, low income women, wouldn’t go near (smoking cessation services), you know, they just wouldn’t...they feel they’re being judged. So if you look at pregnancy, low-income [few words] pregnancy, and the women that we worked with would say ‘oh they’re only interested in me now that I’m pregnant, they’re not interested in me, they’re interested in the baby’. So the perception was that’s the only time anybody showed any interest in them, you know, ‘why should I be interested in that’. And all they’ll tell you, you’ve got to stop smoking for the sake of the baby, no strategies to help. So very much- that’s their view of it. **(Advisory Group)**

R11 went on to discuss in further detail the potential impact of smoking cessation interventions on pregnant women:

**R11:** But certainly I remember sitting with a midwife who had a photograph, or she had this drawing of the baby in the womb, and the cigarette, and all this going into the baby, and, you know, she showed it to the mother. Now you can imagine, if they are, if it’s right what, you know, and it is, that nicotine is as addictive as heroin and cocaine, ok, and you’re faced with someone who’s been smoking since they were 15, and they’re targeted by the tobacco industry to get them smoking, and that they become addicted very very quickly, and you then say ‘look what you’re doing to your baby’. You are never going to engage with that person. So it’s a fear, so you’ll get women lying about their smoking, or underplaying it, saying ‘oh I don’t smoke as much as that, and I’m going to stop’. Anything to stop what they perceive as the intrusion. **(Advisory Group)**

This interviewee (R11) argued, therefore, that pregnant women might interpret any focus on their smoking during pregnancy as an ‘intrusion’. ‘Victim-blaming’ was perceived as a particular consequence of targeting this group, especially where quit attempts were unsuccessful. Furthermore, the ethical issue of placing additional



stress or pressure on women at such a vulnerable time was also highlighted. These concerns were reiterated by several interviewees, some of whom suggested that smoking cessation services should be targeted at women prior to pregnancy (e.g. when receiving contraceptive services). In LHCC 'A', some advances were made in targeting young mothers within one of the LHCC's practice-based services. This particular Practice had a strong community-based approach, and targeted young mothers in the local nursery on No Smoking Day. Additionally, health professionals within this Practice used the child development checks on home visits to offer brief interventions, and to provide parents with information on smoking cessation interventions.

In addition to concerns about targeting pregnant women, ethical issues were also raised around prioritising other smokers, such as those who were 'ill'. Interviewees discussed the perceived conflict in weighing up the more immediate quality of life benefits that an ill smoker would reap from quitting, against the long term preventative effects in a younger smoker. In the following data extract, interviewee R3A describes the ethical debate that prevailed in the early stages of service development within his/her LHCC:

**R3A:** I don't think anybody prioritises patients- different kinds of types of patients, actually. I think there was a big debate about that early on in [LHCC name], but that...was not resolved, because nobody felt they could balance a young woman against the older man who already had some kind of, you know, lung condition or heart condition. How do, you know, how do you weigh up- she's got her whole life ahead, and you could be preventing an awful lot of ill health, whereas he will really benefit from giving up smoking now. It's not easy to prioritise I don't think. (LHCC Management/Strategy/Co-ordination)

Interviewee R3A worked in an LHCC where little evidence of prioritisation/targeting was evident from interviewee accounts. In some LHCCs, the smoking cessation services formed part of a secondary prevention approach. In such cases, the focus was on 'at risk' patients who fell within a particular disease category (e.g. COPD, diabetes, asthma). Within individual GP practices, smoking cessation was also sometimes approached as part of broader chronic disease management (CDM)

intervention. This was discussed at length by one health professional who worked within a Practice in a low-income area. In the extract below, this respondent discussed how low-income patients were not seen as a 'target-group', given that the practice was located in a low-income area. Instead, s/he argued that attention was focussed on *medically* 'at risk' groups:

**R5B:** Em a lot of our patients are in low-income groups, and we don't particularly identify them as a group, if you see what I mean, within the Practice. And our view tends to- certainly at the start of it all, my view was that we should treat people at high risk...of an event, of an adverse health event, em, because ...em...because there you'll get some short-term benefit. If you stopped somebody smoking, over the next year or two, you'll get some chance of preventing an adverse event. If you stop a young person smoking, the chance of seeing any benefit for twenty or forty years is minute, in health terms...em, I mean if they're asthmatic or something, but in preventing death....

**Int:** So you tend to prioritise people at high risk from a medical complaint?

**R5B:** Yes, that's what I do, and I think that's the feeling within the Practice. Certainly all the things that we've set up, like chronic disease management clinics, they're focussed very much on the people at high risk, and smoking cessation plays a part in those, because that's where...it's only that where most of the measurable activity within the Practice to do with smoking ...is focussed.  
(Service Delivery)

Interestingly, respondent R5B appeared to trivialise the potential health benefits of a young person quitting smoking, despite clear benefits regarding illness prevention. Instead, this interviewee appeared to place more importance on the 'tangible'/short-term benefits of smoking cessation. That is, smoking cessation was perceived as a key strategy within a secondary prevention framework and chronic disease management framework.

Interviewees, therefore, described the issue of prioritisation from various ethical standpoints, and from a chronic disease management perspective. It was clear that the lack of priority assigned to the development of services to address the needs of the three target groups was partly underpinned by such ethical and clinical standpoints. However, many interviewees also claimed that the Primary Care setting

was not an appropriate setting for targeting the groups highlighted in the White Paper, particularly young people. It is this issue that will now be discussed.

#### **8.4. Smoking cessation and the primary care setting**

As described in the section above, according to interviewees, little direct targeting was taking place in the majority of the LHCCs. Issues around funding and attitudes towards prioritisation were two of the factors underpinning this. However, interviewees also frequently commented on the appropriateness of the primary care model for reaching these groups.

Some interviewees suggested that the way in which the smoking cessation services had been structured in Scotland, as health-service based, was not the most appropriate means of delivery. Specifically, interviewees claimed that a health service based approach limited the range of smokers that could be reached by services. It was also an approach that was argued to rule out other effective ways of targeting and helping smokers. Many respondents argued that the services in Scotland were overly-focussed on a health service format:

**R11:** If you look at cessation in Scotland, it's very health service driven. So you've got cessation services in every health board area. But what we haven't got is, em, say you're working with a young person, and they come and say they want to stop smoking, but they're using cannabis and tobacco, or even alcohol and tobacco, and that's [few words?]. We need to intervene where those young people go, or where that person goes. Now they're not necessarily going to go to a cessation service in the Health Board.  
**(Advisory Group)**

The health service setting was perceived by many interviewees as inadequate for reaching all the target groups specified in the White Paper. There was a general consensus amongst interviewees that pregnant women and 'high risk' (i.e. ill) patients could be targeted through primary care, given their increased contact with their midwives, GP, or pharmacists. Midwives in particular were perceived by respondents to have an important role in targeting pregnant women, although this profession appeared to play a very minor role in service delivery across the LHCCs.

Several health professionals providing intensive smoking cessation support stated that pregnant women would be 'fast-tracked' for intensive support, but intimated that it was the midwife's role to assess and refer pregnant women. However, a very small number of referrals for this group was reported by interviewees. One health board employee (R1H) discussed that there were difficulties in engaging with the midwifery profession in the early stages of service development within the Health Board. Respondent R1H discussed a perceived lack of time commitment from the midwifery profession, and the difficulties involved in getting staff released for training:

**R1H:** There is a problem with shortage of midwives, and how they're going to run the smoking cessation groups. You could argue smoking's such an important topic, they wouldn't need to run as many asthma clinics and all that sort of thing, if there was smoking cessation. But they tend to see everything [one word?] as priority. So there's that, and there's been a whole re-structure as well, and midwives having more responsibility for the birth process- I think- rather than the obstetrician. So because of all of that big change in the maternity strategy, there just hasn't been the time commitment. What has been happening is we've been running training, but there's a huge amount of interest to come on the training, but in reality, getting released to go on the training is difficult. **(Health Board)**

Although R1H above suggested that there was an interest from this profession in being trained to provide smoking cessation support, other priorities and time commitments in midwives' workloads was perceived to prevent this happening in practice.

With regard to young people, and also low-income groups, it was widely argued that (a) primary care was not a suitable setting, and/or (b) that wider initiatives beyond cessation services were required:

**R5B:** I think with pregnant women, probably doing it through the midwives, in a medical context, is probably as effective as any, in actually stopping people- because what you want to do it to cut down or stop smoking for a few months, that's your goal. For young people, contacting them in school, and through youth clubs, is probably going to be more effective than doing it through

primary care, because by-and-large you're going to have [useful?] contact [few words?] primary care, I guess. And em...the deprived, I think by-and-large that needs to be done by em...economic, social measures, starting with healthcare measures. But our role primarily I think is for the high-risk people, who are already in contact with our services, and already have the disease.

**Int:** right...so with low-income, you're talking more about the broader structures...

**R5B:** yes. (Service Delivery)

With regards to tackling smoking in low-income groups, respondent R5B above clearly highlighted the need to tackle the underlying social and economic factors influencing health. Similarly, in relation to young people, the health service setting was not deemed, by this respondent, as appropriate for tackling this group. With regards to accessing young people, many respondents advocated an alternative means of reaching this group. It was claimed that people of this age would have less contact with primary care services. A school-based setting was therefore advocated by some interviewees as being a more appropriate setting for reaching young people:

**Int:** do you find that a lot of young people come along to these groups?

**R3B:** no. You've got to be very confident to come to a group- I've had a couple of teenagers, but it's been quite difficult.

**Int:** is it better with one-to-one?

**R3B:** young people haven't got health problems ...why would you stop!- you're fit...young...cool.

**Int:** do you think the new [Health Board's pharmacy project ] project- I'm not sure if it's been rolled out into [LHCC name] yet, but...

**R3B:** it's not here yet, and I think that will be interesting. I think the fact that young people do use chemists a lot is very useful, and ...I don't know, I think maybe there's scope for- don't start me, because I'll just get...- I think there's scope for quite a lot of creative work, with schools, but you can't prescribe anything. (Service Delivery)

Respondent R3B went on to distinguish between the 'Medical Model' and the 'Education Model':

**R3B:** So we're not in the Medical Model, we're in the Education model. But I think if we could get the minds of education- something like their bullying policy, you know, and health

promoting schools- we could go down that line, with health workers. And that's coming, because Health Visitors are now trained as joint school nurses. **(Service Delivery)**

In making this distinction, interviewee R3B suggested that an education policy in schools might be a more appropriate method of targeting young people than via a health service model. The Health Board's pharmacy project highlighted above, was a pharmacy-based smoking cessation project aimed at young people and pregnant women, funded through separate means from the White Paper money. It was being trailed in several LHCCs, within specific low-income areas at the time of the interviews. Many interviewees were taking a "wait and see" approach regarding the project, as well as to other projects, such as a project with young people that was being pilot in LHCC 'G'. At the time of conducting the interviews these projects were in their infancy, and many interviewees said they wanted to see how these performed before embarking upon a local strategy.

The argument for using schools as a means of reaching young people was not only centred on the 'access' issue, but also on the role of prevention. Specifically, it was recognised that reaching young people before they *started* smoking would be a more effective means of targeting them than after they started, or later on in their lives:

**Int:** what- with regard to the young people- I mean what do you think needs to be in place to be able to kind of...?

**R5E:** I think probably more importance on the factor [of?] school...definitely, eh...and from a young age as well, not necessarily waiting 'til high school age. For me personally, I would say getting them at primary schools, and educate nine/ten year olds on the dangers of smoking. They're getting a wee bit about that, but I think there needs to be a lot more input there, 'cos it's obviously far easier if somebody doesn't ever start it...than once they've started. **(Service Delivery)**

Within a couple of LHCCs, there were pockets of activity in efforts to target young people. For instance, in two Practice areas, within different LHCCs, work within schools had been carried out by, for example, community education workers, school nurses, and health visitors. In one of these Practice areas this approach may have been adopted because of the Practice's strong community ethos. That is, respondents



described that this Practice was proactive in working in partnership with the community and the local SIP team (Social Inclusion Partnership). In the other Practice area the local school had, what was termed, a 'drop-in health service' within which the smoking cessation work was accommodated. However, some interviewees described local plans to reach the target population through schools. For example, the health professional cited in the following extract had carried out intensive smoking cessation support for his/her Practice patients. S/he expressed disappointment, however, that no young people had been referred. Consequently s/he intimated that targeting schools for intervention would be a more fruitful means of accessing this particular group:

**R4D:** I haven't had any referrals...of any young people, and that's probably because none have come through the door, em, which is a slight disappointment for me now, because I'm actually thinking it's time I went into schools. And eh, I think that would be my next step forward, would be to phone up one of the local high schools, look towards taking a package forward and doing some work within the schools, and using the same skills that I've got...I've got teenage sons, so I feel that I'm equipped to deal with that and move in there, and maybe look at needs there. **(Service Delivery)**

Overall, therefore, there was an argument that the primary care model was not the most appropriate for reaching young people. Similarly, with regard to low-income groups, a primary care smoking cessation service was not necessarily understood to be the most effective means of targeting this group. In relation to low-income groups discussions tended to be couched in arguments for a broader tobacco control strategy and a multi-faceted approach that dealt with other social issues:

**R5B:** I suppose I don't really think managing smoking cessation on an individual or a Practice level I think is likely to make much difference. The whole structure needs to change. The...advertising needs to stop, and we need to stop promoting, you know, sport and music and things, em tax [few words?] controlling it a lot more, import controls, there's lot of cigarettes on the black market, sort of half smuggled in- they go cheap, so you get them cheaply- and people's circumstances need to improve so that they can raise heads above the parapet and decide their life's worth living, without a cigarette. And those are the things that will make a difference. **(Service Delivery)**

In addition to broader strategies tackling wider social issues, several interviewees claimed that a linked-up approach might be one way to reach low-income groups. One interviewee (R2B), for example, talked about a blue-sky vision within his/her LHCC to provide smoking cessation support as part of a wider social support service:

**R2B:** As I say, people who live in areas of deprivation, may well be smoking as a survival technique, you know, and actually may have real problems going on in their lives that actually need to be addressed. So I think one of the first things would be they'd all be self-referrals to it, because that in a way is part of the brief intervention process- we know that people are motivated to stop smoking, if they've actually made the effort to contact the smoking cessation provider. So, that person would contact the smoking cessation provider, who would then meet with them and, you know, look at...sort of assess to see what they actually require. And if it's in a social inclusion partnership area, there are a lot of voluntary organisations in that area that can provide counselling, support groups for mental health problems etc- we'll send that patient...as well. So, we need to take into account all of that sort of thing, and so the smoking cessation provider would be telling them about these other services as well. (**LHCC Management/Strategy/Co-ordination**)

This need for a linked up approach was highlighted by several interviewees. There was also a suggestion that a community-based approach would be helpful in reaching this group. The interviewee cited in the extract below discussed community-based 'healthy living centre' groups, whereby community members decided upon local priorities for local action. In this case however, smoking cessation was not reported to be one of the priorities chosen by the local community:

**R2F:** But my concern- and I really will be very disappointed if that doesn't happen, if we don't have smoking cessation in communities by community development, you know the community development approach. But I have a fear that these healthy living centre groups are actually not going to choose smoking cessation as one of their priorities. Em, I know it's public, I don't know, were you at the public health day that there was, and people were, there was a presentation on smoking...

**Int:** No...

**R2F:** Well that was somebody through the healthy living centre and community development, and the smoking cessation thing had not worked because people in the actual community, that wasn't

their priority. So...there are, there are issues there. (**Service Delivery**)

The fact that smoking cessation was not seen as a local priority was therefore a source of frustration for this interviewee, particularly given the perceived benefits of a community development approach. However, one health professional who worked in a low-income area discussed that smokers within low-income communities may not necessarily perceive smoking as an 'issue'. Consequently, this respondent argued that there was an incompatibility between top-down approaches to tackling smoking (i.e. smoking being defined as an 'behaviour/issue' to be tackled by the medical profession) and the way in which smoking was perceived by those living in deprived communities:

**R5B:** My personal belief is that's...it might be years away, or generations away, if you use that approach [Community Development] apparently starting off with smoking as the issue. You might be a long way away from actually altering the smoking habits of a population, or a group, or an individual. Smoking has been identified by the medical establishment as being an undesirable activity. It's not being identified by individual people in the population as an undesirable activity. They smoke for various reasons- they might hate themselves, or feel guilty about it- but their priority isn't necessarily to stop smoking in order to prolong their lives, or prevent a heart attack. (**Service Delivery**)

The respondent cited above therefore described a conflict between the role of smoking within the context of people's lives, and the role of the medical profession in trying to encourage people to quit.

In discussing the suitability of smoking cessation interventions within primary care, therefore, there was an argument that the issue of smoking should be considered within a broader socio-economic framework. The next section of this chapter will go on to discuss this issue in more depth. It will consider interviewees' accounts of the smoking cessation services in light of the perceived role of smoking in people's lives (particularly regarding low-income groups), and the perceived role of addiction.

## 8.5. Smokers and addiction

Several interviewees discussed the ‘meaning’ of and role of smoking within low-income groups. Firstly, there was discussion around the normality of smoking in low-income communities, and implications for the role of smoking cessation services. The data extract below highlights the perceived ‘normalisation’ of smoking within low-income communities. This interviewee intimated that smoking cessation services played only a small part in changing smoking behaviour within such communities as a result:

**R11:** Now if you go to areas of deprivation where people are in low-income jobs, there are no policies, they’re very poor (policies), and smoking’s the norm, if you like, it’s the normal thing to do. And I often speak to women that say, ‘it’s a load of rubbish about this smoking damaging your baby, my pal had a baby the other week and it looks perfectly OK to me’. Do you see what I mean? So, em, they’re living in communities where there’s lots of smokers and they don’t see, they think it’s normal for somebody to die in their 60s. Whereas that’s 20 years off somebody’s life. They think that’s, that’s not out of the ordinary. So, you know, you’ve got to change that, so it’s much broader than just simply dumping [one/two words] cessation services. (**Advisory Group**)

Interviewee R11, therefore, appeared to argue that smoking cessation services did not adequately address the broader socio-economic factors that may act to ‘normalise’ smoking behaviour in low-income communities. One interviewee discussed the importance of implementing greater social and economic strategies to tackle some of the difficulties that people in low-income groups faced. Specifically, this health professional discussed the day-to-day difficulties that his/her patients endured, and implications for the provision of smoking cessation interventions within the consultation:

**R5B:** Being in a Practice like ours [low income], it [smoking cessation] very often takes second place to eh...to...helping patients cope, because they have so many issues. You know, very often it’s just not something...to take an extreme example, [few words?] ‘this isn’t time to try and stop smoking’, you know, they come along, their lives are in a mess, and they want to do something about it, and sometimes, you know, you start them on anti-depressants, they’re trying to cut down their alcohol, or they’re

trying to look after their children, get them out of care, or whatever, and they say ‘oh I need to stop smoking because it’s not doing my children’s asthma any good’. And they’re absolutely right, but you know, you can’t deal with that when you’re on anti-depressants. Occasionally I tell people ‘don’t give up smoking now, it’s not the time to do it’. So the more middle of the road thing is just...the patients have other things on their agenda. So, by and large, medically it’s a priority, it does have to take second place to comforting the patient and helping them cope. There are other pressures on us to keeping the whole smoking industry alive, and that should be challenged, publicly, both by altering the whole financial set-up, low unemployment [few words?] smoking, and em...leaving deprivation. **(Service Delivery)**

The interviewee cited above described how smoking cessation was one of many issues that patients in low-income groups faced. S/he argued that the medical imperative to encourage quitting among these smokers was not necessarily always appropriate. Smoking cessation should, s/he argued, be accommodated within a broader strategy to improve people’s lives circumstances.

Several interviewees proposed that a Practice-based approach to smoking cessation accommodated an understanding about patients’ lives and the social context that sustained their smoking behaviour. Two of the LHCCs in this study adopted a practice-based approach, whilst others adopted a mixture of practice-based and centrally-provided support. Interviewees perceived having access to patients’ medical notes, as well as being familiar with the patient’s medical/social circumstances, as beneficial:

**Int:** how do you find the Practice-based approach?

**R3E:** it’s probably easier, because a lot of the time you’ve got notes in front of you, you’ve got histories, you’ve got drugs the patients are on...obviously if patients are taking certain medication, Zyban isn’t an option. You have all that information in front of you. So if you are seeing patients...a lot of them you have already met in the past, you know their history, you know their background, you know lots of social aspects of their life, you know what would influence their smoking cessation decision. **(Service Delivery)**

Interviewees also talked about the role that smoking played as a coping strategy in people's day-to-day lives. Specifically, it was argued that there should be greater understanding of what smoking as an activity might offer to people in low-income groups, rather than just focussing on cessation. For instance, one interviewee argued that it was unethical to encourage people in low-income communities to stop smoking, unless they were provided with additional support to help fill the void:

**R2B:** And when you talk about people who are living in deprived communities, smoking for them is a survival mechanism, and I don't think we should actually be saying 'stop smoking', until we provide them with something else that gives them more optimism in their lives. **(LHCC Management/Strategy/Co-ordination)**

Another respondent, cited in the data extract below, also discussed the role of smoking in peoples' lives, particularly within low-income communities. S/he described the role of smoking as both a social activity and a coping mechanism, and compared the harmful *physical* effects of smoking with potential *emotional* benefits:

**RIA:** It's also about understanding why people- particularly on low incomes- smoke at a higher proportional level than other groups in our society, and what that actually does in terms of their ability to kind of relax and find personal space, and that if you're going to demand and force them to stop smoking by whatever, you know, by advertising, by pressure, by any other means, then the quid-pro-quo of that is you have to find some other way that is going to help them to kind of relax and find personal space. One of the things you find if you work with low-income mothers who smoke, is that having a smoke is about the only peaceful thing of the day. They retreat to the kitchen or somewhere and have a fag, and the kids, 'they can do whatever the bloody hell they like, but this is my personal space, and my personal time'. That's probably actually more beneficial for their health than the down side of having the soddin' fag! **(LHCC Management/Strategy/Co-ordination)**

Given the perceived importance of smoking within the contexts of people's lives, this interviewee argued that simply providing cessation services was not sufficient. Instead, s/he argued that a greater understanding should be sought around why people in low-income groups may smoke more than other social groups, and the significance of smoking in their lives:



**R1A:** Em...so it's the...there's a lot more kind of subtle work I think needs to go on there in terms of changing people's...not even their attitudes...it's changing other people's attitudes I think, about why people smoke, you know, because...there's this idea...'it's self inflicted, it's your own soddin' fault!'. (**LHCC Management/Strategy/Co-ordination**)

Both respondents (R2B and R1A) cited above had professional working backgrounds in community development and/or low-income areas. Consequently, they claimed to understand the types of issues affecting low-income groups. The above extracts illustrate ethical arguments against promoting smoking cessation without providing access to, or the means to adopt, alternative coping strategies. The latter extract (respondent R1A) also highlights two other important issues. The first is the perceived need to challenge attitudes towards people who smoke. A second, and related issue, is that of 'victim-blaming'. Traditional models of health promotion, incorporating behaviour change and prevention approaches within a medical context, have been criticised for eliciting a victim-blaming ethos. An emphasis placed on individual behaviour change decisions has been acknowledged as undermining the important role played by wider structural influences on health. Indeed, in the previous two extracts from interviews with respondents R2B and R1A, the distinction between individual responsibility and the need for social and economic interventions to tackle smoking in low-income groups, was clearly highlighted.

Many respondents therefore appeared to be aware of the difficulties in reaching low-income groups, and the wider structural factors mediating their smoking behaviour. To reiterate, there was little direct targeting taking place within the LHCCs. However, in LHCC 'G', the targeting of low-income groups was a specific priority. Consequently, respondents from this LHCC discussed that in the early stages of service development, the first priority was to establish accessible services in low-income areas. An interviewee from LHCC 'D' also discussed how local services were tailored to meet the needs of low-income groups:

**R1D:** We don't expect them to travel far, we want everything on their doorstep, the leisure centres were used, and they would get like a free swim or something, and – just so there was something

that [few words?]....just do the holistic health promotion kind of thing. We do also get the dietician into the groups as well for one session, and a lot of what she talks about is kind of like healthy eating - on a budget, things like that. **(LHCC Management/Strategy/Co-ordination)**

Interviewee R1D, therefore, highlighted the additional strategies required to engage with low-income smokers. However, an interviewee from another LHCC had quite a different view of what was required to engage with low-income groups:

**R1F:** And the low-income groups, I think we deal with them pretty fairly anyway. I think they get as fair a whack at it as anybody...and um...target them...well...I can't see that putting in anything extra would give them anything in addition to what they get already. They get a fair whack at everything that's going. They can be referred in, the opportunity's there, they'll be seen, they get their prescription...um...so I don't really know what more we can do. **(Service Delivery)**

The smoking cessation service within respondent R1F's LHCC was delivered on a 'locality' basis (ie. groups run in different geographical areas for local people). It may have been the case, therefore, that access to services was not perceived by R1F to be a barrier for low-income smokers. However, R1F's suggestion that low-income groups did not require any additional support and/or effort than other smokers contrasted sharply with R1D's account, suggesting varying perceptions regarding the strategies required to engage with this group of smokers.

Several interviewees also commented upon attitudes towards smokers, particularly in respect of GPs. Specifically, it was proposed that the role of nicotine addiction in sustaining smoking behaviour was not always acknowledged by GPs:

**R2F:** I think one thing that distorts people's views, em...GPs in particular. I don't think that, I think a lot of people do not accept the strong addiction of nicotine. It's only in fairly recent years that that's actually been part of the health education, you know, with, you know, for decades there's been that smoking is bad for you, smoking does this that and the other, but what there hadn't been until very recently, and I still don't actually think as far as the young people are concerned the message is given hard enough, that nicotine is actually extremely addictive, that's not actually a

lifestyle, it's not just a lifestyle- people talk about it as a lifestyle choice, and it's not a lifestyle choice, it's an addiction. **(LHCC Management/Strategy/Co-ordination)**

Respondent R2F went on to discuss how many GPs perceived smoking as a 'lifestyle choice', which was perceived by R2F as having implications for the delivery of smoking cessation services:

**R2F:** I think a lot of them [GPs] still feel that it's actually a lifestyle choice, and 'why should they be devoting too much time to this because if people just decided they would stop, they would stop themselves'. **(LHCC Management/Strategy/Co-ordination)**

Several other interviewees also discussed how understandings of addiction had implications for the services which smokers received. For example, the health professional cited below, reflected on how GPs dealt with smokers. In particular s/he argued that nicotine addiction was not always entirely understood, or dealt with effectively by GPs:

**R3D:** There's a real misunderstanding amongst staff- the doctors even- about how difficult it is for people to stop smoking...about the nature of addiction. I really do believe that they don't fully understand. Now our senior partner here- love him to bits, I really do- but it's not the first time he's actually gone and said to a patient 'right, give me your cigarettes', and he's taken them from them, crushed them up and put them in the bin, in front of the patient- 'now that's the last time I ever want to see you smoking a cigarette'. Now that just doesn't work. So there's definitely a lack of understanding of em...what...of what addiction is. **(Service Delivery)**

Thus a lack of knowledge about the role that addiction to nicotine played in smoking could, it was argued, lead to smoking cessation being dealt with ineffectively by GPs. As was the case with the perceived role of wider social and economic factors underpinning smoking behaviour, many respondents intimated that the role of addiction in smoking behaviour should not be underplayed.

This section (8.5.) has highlighted interviewees' perceptions of the role of smoking in people's lives, particularly amongst low-income groups. It has also highlighted the

importance attached by respondents to the role of addiction in smoking behaviour and implications for smoking cessation service delivery. Many interviewees also argued that smoking cessation should be looked at within a wider social and economic context, whilst also addressing broader tobacco control issues.

## **8.6. Chapter Summary**

This chapter has discussed interviewees' perceptions around various aspects of the smoking cessation intervention. The first section highlighted that the provision of brief interventions (particularly by GPs) was commonly perceived to be ineffective and inefficient. Respondents described smokers as being either inappropriately referred for intensive cessation support (i.e. when not sufficiently motivated to quit), or being prescribed NRT or Zyban with no offer of further support. The chapter then went on to discuss the extent to which service development/delivery (particularly regarding the issue of targeting), and perceptions around the smoking cessation strategy, were informed by the perceived appropriateness of the primary care setting for smoking cessation interventions, and varying ethical and theoretical standpoints. In particular, respondents' accounts were couched within considerations of the ethics of targeting, and reflected upon wider theoretical frameworks relating to the stages of change/motivational approach, broader health promotion models/approaches, and the nature of addiction.

# CHAPTER NINE

## Discussion

The aim of this chapter is to outline the main findings of the research within the context of relevant literature and implications for practice. The chapter begins by outlining the main approaches to service delivery that were adopted within each of the LHCCs. Reflection on the factors underpinning service development/delivery within the LHCCs will occur through the process of discussing the broader findings of the research, which constitutes the main body of the chapter.

In Chapter three (Methodology) it was discussed that in reflecting upon the research findings, it would be useful to consider Wolfe's (1994) critique of diffusion of innovation research. Wolfe argued that in considering the diffusion/implementation of an innovation/strategy within an organisation, it was important to define the *characteristics* of the *innovation*, and to consider the organisational context within which strategies may be implemented. Wolfe proposed that this would allow for greater generalisability (and applicability) of research findings. My research was not guided by Diffusion of Innovation Theory as a theoretical framework. However, I felt that Wolfe's recommendations for reflecting upon the interaction between the characteristics of a given strategy, and the context within which it is implemented, provided me with a useful framework for considering my research findings, and its implications. This chapter, therefore, is structured to delineate the key factors surrounding the implementation of not just a smoking cessation strategy (*innovation*), but a health promotion strategy (*innovation*) implemented within the primary care setting (*organisation*). There are four main parts to this chapter:

- 9.1. Outline of LHCC smoking cessation services
- 9.2. Health promotion, smoking cessation and primary care
- 9.3. The NHS smoking cessation strategy
- 9.4. Key factors underpinning service development

## **9.1. Outline of LHCC smoking cessation services**

To reiterate, following the allocation of *Smoking Kills* funding from the Health Board, LHCCs were assigned responsibility to develop smoking cessation services in accordance with local population needs. At the time of conducting the fieldwork for this research, three predominant approaches to service delivery had been adopted across the LHCCs. These approaches included, practice-based support (two LHCCs) centralised group/one-to-one support (two LHCCs), and a combination of practice-based and centralised group support (three LHCCs). In the main, it was health visitors, practice nurses and other nursing staff (i.e. primary care nurses; district nurse; smoking cessation nurses) who provided the intensive smoking cessation support. Within three LHCCs, pharmacists also played a prominent role in the delivery of intensive one-to-one and group support.

There was considerable variability with regards to the pace and form of service development within the LHCCs, and the factors underpinning the service development process. However, discussion and reflection around the key factors associated with the development and delivery of local smoking cessation services, and the predominant issues around smoking cessation services more generally, will be addressed in the remainder of this chapter.

## **9.2. Health promotion, smoking cessation and primary care**

### **9.2.1. The primary care setting**

In reflecting upon the process of the implementation of the smoking cessation strategy, it is important to consider the organisational context within which it was implemented. The “*inner context*” of an organisation has received particular attention in the literature as being an important factor to consider in the diffusion/implementation of a given innovation/strategy. Fiol (1996) attributed the potential of an organisation to integrate new working practices required for the successful adoption of an innovation to its “*absorptive capacity*”. Fitzgerald *et al.* (2002) described ‘absorptive capacity’ as “...*the inner context of the organisation’s boundary, the history, the culture, and quality of inter-professional relationships*”



(p.1446). The 'inner context' of an organisation has also received prominence in the organisational change literature. Pettigrew *et al.* (1992), define *context* as a crucial 'shaper' of change, whereby it provides a crucial link between the *content* and *process* of change. The 'inner context' of an organisation was defined by Pettigrew *et al.* (1992) as encapsulating the organisation's internal structures, culture, management, and political processes. Given the importance attributed to the context of an organisation in shaping the strategy/policy implementation process, it is important to consider the context within which the smoking cessation strategy was implemented.

Within the Health Board under study, the smoking cessation services were implemented within primary care. In considering the implementation of the smoking cessation strategy within primary care, it is therefore important to consider the inherent nature of this setting, and how this may have impacted upon the strategy implementation process. McCormack *et al.* (2002) described *culture* as being an important sub-element of organisational context. It has also been defined as "not something that an organisation *has* but something an organisation *is*" (Bate, 1994, p.12). McCormack *et al.* (2002) attributed culture to an organisation's values, including traditional orientations around staff roles and relationships. With regard to roles and relationships, primary care has been described as having a unique context that differs from the acute sector (Fitzgerald *et al.*, 2003; Fitzgerald *et al.*, 2002). These authors described the 'network' characteristic of primary care, whereby the delivery of primary care services is achieved through the co-ordination and effort of various professions (GPs; health visitors; pharmacists; district nurses), with GP practices at the core of this structure. With regards to health promotion practice within primary care, the literature suggests that there is a traditional system of roles and relationships, and an inherent divide between nursing staff and GPs.

A key issue in the literature around health promotion in primary care, is the traditional *delegation* of health promotion activity from GPs to practice nurses, or other members of the practice team. Research investigating the health promotion role of GPs and practice nurses, has indicated that practice nurses perceive health

promotion to be more relevant to their own personal work remit, and believe that they have more time to carry out health promotion activity (Steptoe *et al.*, 1999; Broadbent, 1998). GPs, on the other hand, have been reported to see their role in the treatment of illness/disease, as opposed to illness prevention through lifestyle advice/health promotion (Broadbent, 1998; Hopton, 1996). In this study, it was found that health visitors, nurses, and practice nurses played a substantial role in the provision of intensive smoking cessation support across LHCCs. Indeed, for those who were involved in doing so, smoking cessation was largely perceived as falling within their professional remit and skill-base.

However, the smoking cessation guidelines (Raw *et al.*, 1998a; HEBS & ASH Scotland, 2000) clearly identified a key role for GPs. This profession in particular was identified as constituting the first port-of-call for most patients given their increased contact with patients. The guidelines, therefore, assigned GPs a prominent role in the delivery of the new services through the provision of brief interventions and referral of patients to specialist support services. However, this study found that GPs were perceived to be ambivalent about their smoking cessation role. Some interviewees reported that GPs played an active role on referring patients on for support, and took an active interest in smoking cessation activity. However, in many cases it was perceived that GPs maintained a certain 'distance' from smoking cessation. Firstly, there was a perceived reluctance for this profession to undertake training. Secondly, several interviewees reported that GPs asserted their 'gate-keeping' role through a reluctance to release their practice nurses for smoking cessation work. This difficulty regarding the release of practice nurses was also encountered in the development of smoking cessation services in Health Action Zones in England (Adams *et al.*, 2000). Finally, GPs were also not perceived to be carrying out brief interventions effectively across the board.

There was a perception that responsibility for tackling smoking cessation was often delegated by GPs to other members of the practice team. The practice nurse role, in particular, has been identified as being part of an "*absorbing mechanism*" (Laughlin *et al.*, 1994a,b; Laughlin & Broadbent, 1995; Broadbent & Laughlin, 1997).

Specifically, this term has been used to encapsulate the ‘absorption’ of work meant for GPs by practice nurses, to allow GPs to carry out other duties. Indeed, several interviewees (health visitors and practice nurses in particular) made reference to the fact that GPs had delegated their smoking cessation responsibilities to them, and others within the practice team. Many interviewees, therefore, perceived that GPs were not as actively involved in the provision of smoking cessation support as they should have been. This issue was discussed within the context of referrals and the provision of brief interventions, which will be discussed in the next section around GPs and evidence-based practice. One GP reported that nurses had a more compatible skill-set, and that it was also easier for nurses to dedicate time for smoking cessation/health promotion. This view reflects the *allocation/delegation* debate around the division of work within the primary care team. ‘Delegation’ has been proposed to assume a hierarchical relationship within the team. ‘Allocation’, however, defines a way of working whereby work is allocated accordingly to the specific skill-sets of health professionals within the primary care team (Richards *et al.* 2000; Jenkins-Clarke & Carr-Hill, 2001). Many of the health visitors/practice nurses perceived smoking cessation support to fall within their traditional work remit. However, given a perceived lack of GP involvement/interest in smoking cessation work, many interviewees perceived that this work had been delegated.

Another profession that played a role in service provision was pharmacy. Within three LHCCs in particular, pharmacists played a prominent role in the provision of intensive smoking cessation support. Previous research has indicated that health promotion activity has increasingly become an appropriate and accepted role within community pharmacy (Blenkinsopp *et al.*, 2002; The Scottish Executive, 2002c; Anderson, 2000). With regards to smoking cessation, research has indicated that pharmacists perceive this activity to be part of their existing role, particularly within the context of NRT administration (Blenkinsopp *et al.*, 2002). Several pharmacists/pharmacy advisors were interviewed as part of this PhD research. For those pharmacists that *were* involved in providing intensive smoking cessation support, it appeared that smoking cessation was perceived to be an activity that the profession could be actively involved in. Indeed, in two of the LHCCs involving

pharmacists, there was a drive by local pharmacy leads for pharmacists to get involved. For instance, in LHCC 'D', the lead pharmacist who undertook the role of smoking cessation co-ordinator for the LHCC, proposed that pharmacists were looking for ways to extend their role. Smoking cessation was perceived as being a suitable way of utilising pharmacists' skills. In support of research by Blenkinsopp *et al.* (2002), smoking cessation appeared to be understood as an extension of pharmacists' existing role, given that the administration of NRT was a pre-existing activity within pharmacy.

Within those LHCC that utilised pharmacists, they were commonly perceived to be a valuable addition to the local smoking cessation services. In particular, they had in-house premises in which to provide one-to-one/group support, and were perceived to have a high level of access to patients. At the time the fieldwork was conducted, a major pharmacy project was being piloted by the Health Board. This project involved using community pharmacy to target young people and pregnant women. There appeared to be a 'wait and see' approach regarding the effectiveness of this intervention, which would inform decisions to use pharmacists more extensively in service delivery. However, on reflecting upon why pharmacists were not heavily involved in service delivery across all the LHCCs, it appeared that financial factors were particularly prominent.

Previous research has indicated that one of the greatest barriers to pharmacy involvement in health promotion activity is financial (Anderson, 2000; 1996). In those LHCCs where pharmacists were involved, they were paid directly for their services, and not expected to take their time back. Several interviewees commented on the issue of *payment* for pharmacy services, and it was identified as a key barrier to pharmacists getting involved in local service delivery. Given the nature of pharmacy as an 'independent business', it appeared to be essential that a proper support structure (i.e. financial) was established in order to integrate this profession into the local service framework. However, this raises an important issue around professional hierarchies, and power bases. There was less of a structured financial framework in place for other health professions providing intensive smoking

cessation support (namely health visitors), whereby support was often ‘accommodated’ via the ‘time-back’ method.

### **9.2.2. Core work**

Health visitors, practice nurses, and other nursing staff provided the majority of intensive smoking cessation support within the LHCCs, with pharmacists playing a more prominent role in three LHCCs. Although these health professionals had adopted this role, the issue arose of how it was perceived within the context of their core work. The literature around health promotion activity within the primary care setting suggests that there is an inherent difficulty in incorporating health promotion activities within core working practice. With regard to where smoking cessation was perceived to fall within core work, this study found that there was indeed a certain degree of contention amongst primary care staff regarding the issue.

Discussion around smoking cessation and core work issues was centred on (a) increasing and competing demands on staff time, and (b) insufficient resources to fund the provision of efficient services (especially ‘staff time’). Perceived demands on staff time, and resource concerns, have been identified in the literature as two key barriers to the implementation of health promotion in primary care (Lawlor *et al.*, 1999; Naidoo & Wills, 1998; Coppel & Davis, 1998; Hopton, 1996). Chapter six (Personal and Professional Commitment) highlighted that the involvement of health professionals in providing intensive smoking cessation support was often underpinned by an interest in, and enthusiasm for, this type of work. In many cases, LHCC staff discussed that service provision was sustained by staff providing smoking cessation support on a ‘goodwill’ basis, given that it was not perceived to be a ‘core’ work activity. Even when the costs of staff time were met, there was still an issue of staff ‘accommodating’ it within their core work duties, or finding staff willing to provide support.

Health promotion can be perceived as a “luxury extra”, to be carried out when time permits (Naidoo & Will, 1998, p.144). This research highlighted that the extent to which smoking cessation was perceived as a “luxury extra”, was mediated by the

attitude of individual health professionals towards smoking cessation, and how it was perceived to fit within their remit. Specifically, the perception of smoking cessation as 'core' work, appeared to be underpinned by the *priority* assigned to smoking cessation by individual health professionals. Similar to the findings of Hopton's (1996) research, this study found that smoking cessation could be viewed in three quite distinct ways by health professionals in primary care.

First of all, Hopton (1996) found that health promotion could be viewed as a 'specialist activity', whereby there was dedicated time for health promotion work. Similarly, this study found that there were health professionals who were enthusiastic about smoking cessation, but essentially perceived it to be an 'add-on' service. Discussion around demands on 'core' workload were particularly prominent with this group. Despite reported enthusiasm for smoking cessation, it was apparent that it could be surpassed by other perceived priorities within an increasing and demanding workload. It is likely, however, that given initial enthusiasm for providing smoking cessation support, such staff perceived smoking cessation as an important activity within primary care. If time and resources were understood to permit additional smoking cessation activity, it is possible that such health professionals would continue to be involved in providing support.

The perceived requirement for additional funds and resources to facilitate the delivery and sustainability of local services, was a prominent issue with interviewees across all LHCCs. The perception of smoking cessation as an 'add-on' service that was difficult to incorporate into core primary care practice, partly underpinned this requirement for additional resources. However, Hopton's (1996) research highlighted the dangers associated with identifying health promotion activity as a 'specialism' within primary care, which was perceived to require dedicated time and resources. When defined as a specialism, Hopton (1996) found that an effort was required to keep health promotion activity a priority within the workload. Consequently, barriers to carrying out such work were more easily identified. Interviewees in this PhD research frequently discussed the difficulties associated with increasing workloads, and the effort required in keeping smoking cessation on



the local and/or personal agenda. When perceived as an 'add-on' service, therefore, it was clear that smoking cessation was open to the risk of being relegated in light of new priorities/services.

The second category in Hopton's research was health professionals' personal commitment and 'moral obligation' to promote health. Similarly, this study found that there were health professionals who perceived smoking cessation as an 'add-on' service, but it was clear that it was core to their personal agenda and priorities. Similar to Hopton's reference to 'moral obligation', several health professionals discussed their smoking cessation activity within the context of a personal commitment to helping smokers quit. There appeared to be a sense of personal satisfaction and achievement in being instrumental in this process. It was this 'personal agenda' of helping smokers quit that appeared to underpin continued commitment to providing support.

The third category outlined by Hopton (1996) was the perception of health promotion as integral to health professional's 'day-to-day work'. Most health professionals within Hopton's study were reported to fall within this category. Hopton discussed the paradox evident within her research of health promotion being looked upon as something that was done within *day-to-day* (core) practice anyway, and as something that could essentially be 'prioritised'. Within my research, this 'paradox' was not evident. There were several health professionals who provided intensive smoking cessation support, and clearly perceived smoking cessation as core to their work duties. However, these health professionals did not tend to refer to smoking cessation as something that was carried out within their 'day-to-day work'. Instead, it was evident that even for those health professionals who perceived smoking cessation as core to their work, it was an activity that had to be *consciously* prioritised within the workload. In such cases, it was reported that they maintained the priority of smoking cessation within their workload, despite funding or time constraints. Despite this effort to prioritise smoking cessation, health professionals within this group were less inclined to discuss smoking cessation within the context of an 'add-on' service. Instead, it was clear that smoking cessation was something

that was perceived to be an activity that should be 'core' to their work remit, and that efforts would be made to maintain it as a priority.

Smoking cessation was not, therefore, universally perceived to be a core part of health professionals' core work remit. The fact that some health professionals regarded smoking cessation as core to their professional and/or personal agenda, was a positive factor in service delivery and sustainability. However, the difficulty experienced by many staff in incorporating smoking cessation provision into core working practice, had perceived implications for service sustainability in the longer term. There were particular concerns about service sustainability when those staff 'accommodating' smoking cessation within their workload ceased to provide support. The trend for 'movement of staff within primary care' was one concern, as was the instability associated with the provision of support on a goodwill basis. For instance, even where money *was* available to fund services, there was still a reported difficulty of finding staff to carry out smoking cessation work in certain LHCCs.

Given the difficulties experienced by staff when trying to accommodate smoking cessation work with core practice, one key issue raised by interviewees was the requirement for a dedicated staff to provide smoking cessation support on a consistent basis with the LHCC. It was argued that this would alleviate the pressure on those staff 'accommodating' support provision. A recent report outlining recommendations for the development of Scottish Smoking Cessation Services (PATH, 2003), focused on the issue of staffing requirements for Scottish smoking cessation services. This report was based on an in-depth study of Health Board cessation services throughout Scotland. It highlighted that most Scottish services, like the Health Board under study in this research, were perceived to be under-resourced, and under-staffed. The report recommended the setting-up of more structured smoking cessation services within each Health Board (this issue will be discussed further in section 9.3). As part of this structure, it was recommended that dedicated 'smoking cessation specialists' should be funded to support service provision. Whilst recognising that other primary care staff have a role to play in service provision, PATH (2003) recommended the appointment of a dedicated

smoking cessation practitioner, for each service, who would not *be “attempting to fit the job with other duties”* (p.25). This recommendation was reiterated in the updated smoking cessation guidelines for Scotland (Health Scotland and ASH Scotland, 2004).

This recommendation reflects issues raised in the interviews carried out as part of this study. However, a few interviewees (including a Health Board employee) argued that the appointment of dedicated staff might have a detrimental impact on the provision of smoking cessation support by other health professionals. One interviewee proposed that dedicated staff might indeed engender a feeling amongst primary care staff that smoking cessation was ‘someone else’s job’. The employment of a dedicated resource, therefore, might impact most significantly on the provision of support by those staff who perceived it as an add-on service, particularly where there was no ‘moral obligation’ to provide support. The comment by one interviewee that staff “*would give it up if there was someone else to do it, but they’re quite happy to continue with it just now*”, perhaps indicates the potential impact of the employment of dedicated staff on perceptions of responsibility for smoking cessation work.

In the event that dedicated staff are introduced, an intensive training strategy may play a vital role in engaging a range of health professionals with the smoking cessation strategy. Several interviewees highlighted the role of training in establishing smoking cessation as a core issue to be tackled by health professionals. Specifically, it was argued that the provision of training to as many health professionals as possible, would increase the capacity of primary care to provide smoking cessation interventions. The training of health professionals in providing smoking cessation interventions constituted a key part of the NHS smoking cessation strategy (Raw *et al.*, 1998a; HEBS & ASH Scotland, 2000). Additionally, the importance of training was reiterated in the updated guidelines for Scotland (Health Scotland & ASH Scotland, 2004).

### 9.2.3. GPs and evidence-based practice

As outlined previously, GPs were identified in the smoking cessation guidelines as having a key role in the provision of brief interventions, and in referring patients on for intensive smoking cessation support. One study involving a survey of GPs and practice nurses indicated that the majority (98%) of GPs accepted intervening with smokers to encourage/help them to quit as a part of their role (McEwan & West, 2001). However, McEwan & West (2001) reported that only 50% of GPs reported advising smokers to quit smoking at *all*, or *most*, consultations, while 41% reported that they referred patients to practice nurses for additional support. This research (McEwan & West, 2001) was based on self-report measures, and smoking cessation activity may have been over-reported. In considering the GP's role in providing routine and opportunistic advice, and in referring patients for intensive smoking cessation support, this study highlighted that there were perceived inefficiencies with regards to GPs' role in the brief intervention process.

One of the main problems identified by LHCC staff was the inappropriate referral of patients by GPs to intensive support services. Specifically, it was argued that patients were not adequately assessed at the brief intervention stage. This was perceived to result in three outcomes. First, patients' readiness to quit was not properly assessed at the brief intervention stage, and therefore inadequately referred for specialist support. Second, patients were simply offered a brief intervention and NRT, without being referred-on where appropriate. Third, there was concern that GPs were simply prescribing pharmacological aids (NRT in particular) without additional support.

The report published on the Scottish smoking cessation services (PATH, 2003) highlighted that this was a common problem encountered by smoking cessation across the country, suggesting an inherent problem regarding GPs attitudes towards smoking cessation interventions. The report advocated that more research was required to understand the issues around the provision of brief interventions by GPs, in order to make this process more effective. It was difficult to determine from the interviews within this PhD study what underpinned inappropriate referrals from GPs.

Specifically, it was difficult to establish whether it could be attributed to a lack of guideline *awareness*, *understanding*, or simply *adherence*.

One interviewee, who was involved at a strategic level in developing smoking cessation services within the Health Board, commented upon GPs' reluctance to undertake smoking cessation training. This respondent argued that GPs did not generally perceive smoking cessation to be an activity that they should be involved in. As outlined in chapter two, the literature on health promotion within primary care has highlighted that GPs are more comfortable with their secondary prevention role (Lawlor *et al.*, 2000; Steptoe *et al.*, 1999; Broadbent, 1998; Hopton, 1996). As a health promotion activity, it is possible that GPs perhaps did not perceive smoking cessation as being part of their traditional remit. Many interviewees expressed concern that brief interventions by GPs were limited to the prescribing of NRT or Zyban. Additionally, several interviewees suggested that GPs might value the 'prescription' more than the motivational intervention.

There are a number of possible factors underpinning the difficulty in engaging GPs with smoking cessation services. These are (a) a perceived lack of time, (b) attitudes towards smokers and perceived effectiveness of interventions, and (c) perceived conflicts with patient-centred medicine. A perceived lack of time to implement guidelines in daily practice has been identified in the literature as a significant barrier to guideline implementation by GPs (Hobbs & Erhardt, 2002; Cabana *et al.*, 1999; Sackett *et al.*, 1997). Self-efficacy (belief in ability to implement guidelines) has also been identified in an extensive systematic review as one important attitudinal factor mediating guideline implementation (Cabana *et al.*, 1999). Although not specified by Cabana *et al.* (1999), time could be one important factor underpinning self-efficacy beliefs. Previous research based on a postal survey of GPs' attitudes towards the smoking cessation guidelines (McEwan *et al.*, 2001) reported that only 30% of GPs felt that it was *practicable* to provide routine and opportunistic advice to smokers. Although a definition of 'practicable' was not provided in this research (McEwan *et al.*, 2001), it is possible that the time involved in providing smoking cessation interventions was a key consideration. Indeed, one interviewee who

reflected upon the provision of services within his LHCC, argued that GPs simply did not have the time to offer robust brief interventions in consultations. Prescribing of NRT and Zyban, therefore, may have been perceived by GPs as the 'quick intervention', falling within their secondary prevention role.

Other factors that might affect the success of brief interventions are GPs' attitudes towards smokers, and their perceptions of the evidence-base surrounding smoking cessation interventions. There was an argument from interviewees that GPs viewed smoking as a 'lifestyle choice'. This was perceived to impact upon GPs willingness to spend time on smoking cessation interventions, given that it was perceived to be the patient's 'choice' to smoke. It was proposed that a perceived lack of awareness among GPs about the nature of nicotine addiction, led to inappropriate treatment of smokers in consultations.

In the diffusion of innovation literature pertaining to clinical guidelines, it has been suggested that GPs may 'appraise' clinical guidelines according to the evidence-base (Fitzgerald *et al.*, 2003). Several interviewees, however, argued that there was a lack of awareness around the effectiveness of smoking cessation interventions amongst GPs. The perceived limited impact of smoking cessation interventions has been highlighted previously in the literature as a factor underpinning implementation of smoking cessation interventions by GPs (Fiore *et al.*, 1996; Owen & Scott, 1995). Given the attention since *Smoking Kills* to advancing smoking cessation interventions in primary care, it is worrying that GPs were still perceived to have a lack of awareness around the effectiveness of smoking cessation interventions in primary care.

Research has indicated that policy initiatives that threaten professional autonomy and/or existing roles may be more difficult to implement in practice (Goldie & Sheffield, 2001). Another potential factor impacting upon the provision of brief interventions by GPs, therefore, is how GPs viewed the guidelines within the context of the patient consultations and day-to-day practice. There is a plethora of literature suggesting that one key barrier to guideline implementation by GPs is a resistance to



the “cookbook” nature of clinical guidelines (Cabana *et al.*, 1999; Sackett *et al.*, 1997). Research has indicated that GPs may perceive clinical guidelines as neglecting the differential nature of patient consultations. A recent qualitative study by Michie *et al.* (2004) highlighted that GPs were wary of applying clinical guidelines, which are based on population research, to the individual patient. Indeed, several key studies have indicated that guidelines are applied according to what is perceived to ‘work best’ in specific consultations, with implementation couched within a broader assessment of patient context (Michie *et al.*, 2004; Fitzgerald *et al.*, 2003; Summerskill & Pope, 2002; Cranney *et al.*, 2001). Additionally, central to the ‘context’ of the patient consultation, is the doctor-patient relationship, which is an integral part of patient care. GPs’ reluctance to jeopardise this relationship has been identified as an additional factor mediating guideline implementation (Michie *et al.*, 2004; Summerskill & Pope, 2002; Freeman & Sweeney, 2001).

Only two GPs, and one Clinical Director (previously a Lead GP) were interviewed as part of this study. One of these GPs in particular discussed the difficulty in implementing smoking cessation guidelines within clinical practice. This GP worked in a low-income area, and discussed the social and medical context of patients’ lives. In particular, this GP argued that smoking cessation interventions were not always appropriate if patients had other more pressing issues to contend with (e.g. depression; alcohol consumption; stress). This GP also discussed the importance of balancing the implementation of smoking cessation guidelines, with the responsibility of helping the patient to cope with life circumstances most effectively. This highlights the perceived importance of the doctor-patient relationship. Indeed research has indicated that the discussion of smoking by GPs is mediated by a desire to maintain a positive doctor-patient relationship (Coleman *et al.*, 2000). Opportunistic smoking cessation interventions by GPs, however, have been shown to impact negatively upon the doctor-patient relationship with particular types of smokers (Butler *et al.*, 1998). Although these were only the views of one GP, they highlight the differential nature of the patient consultation, and doctor-patient relations, within which decisions to implement clinical guidelines may be couched.

The updated smoking cessation guidelines for Scotland (Health Scotland and ASH Scotland, 2004) reiterated the importance of GPs in the brief intervention process. These updated guidelines outlined a revised brief intervention process for GPs (and essentially other health professionals offering brief interventions), which signified a move away from the stepped-care approach. This new process stipulates that smokers should be encouraged to use the most intensive form of support open to them (smoking cessation services), and therefore recommended the provision of brief advice to stop, followed by referral to a specialist cessation service if required, and/or a prescription for NRT/Zyban. It was recommended, therefore, that intermediate interventions in assisting smokers to quit should be given less priority. These revised guidelines, however, do not guarantee that GPs will become more engaged with smokers in providing brief interventions. Additionally, the brief intervention process still leaves open the possibility that GPs will refer patients inappropriately for intensive support, and/or simply prescribe NRT/Zyban without the offer of additional support. PATH's (2003) proposal, therefore, that more research be directed at understanding the GP's role in undertaking brief interventions, would certainly be a progressive step forward.

The new GP contract (Department of Health, 2003) might also witness an increased priority assigned by GPs to smoking cessation advice within the GP consultation. This new contract is based on 'quality markers' and offers quality points for the recording of smoking cessation status and provision of advice to quit. Given the importance attributed to smoking to a wide range of chronic health conditions, smoking constitutes nearly 10% of the quality framework. However, whilst the priority assigned to smoking may increase, it may also just lead to the simple recording of smoking status, as opposed to effective interventions.

### **9.3. The NHS Smoking Cessation Strategy**

In considering the factors underpinning the development, delivery, and sustainability of a health promotion initiative, it is important to consider features of the both the intervention *and* the setting/organisation in which it is implemented. Section 9.2.

discussed the broader issue of health promotion within the primary care, and highlighted traditional organisational and professional boundaries underpinning health promotion (and smoking cessation) implementation. However, this section will take the discussion a step further, and consider specific features of (a) the capacity and priorities of the setting (primary care) and (b) the intervention (cessation services) that appeared to impact upon service development and delivery.

### **9.3.1. Smoking cessation services in primary care**

Thorax guidelines (Raw *et al.*, 1998a), and the smoking cessation guidelines for Scotland (HEBS and ASH Scotland, 2000), advocated that young people; low income groups, and pregnant women should be specifically targeted for smoking cessation interventions. However, the implementation of policy/guidelines is not necessarily a linear process. Indeed, policy initiatives implemented at the local level, can be re-formulated in a bottom-up process (Walt, 1994b). This study highlighted that the *setting* within which a policy initiative is implemented, can affect the implementation process. To reiterate, the smoking cessation services within this Health Board were largely implemented within primary care. The issues around implementing smoking cessation services in primary care related primarily to the capacity of services to address the needs of the three target groups. There was very little direct targeting taking place within the LHCCs, with few strategies devised to reach these priority groups. The prioritisation of the three target groups was perceived to be incompatible with (a) the priority primary care assigned to targeting 'ill' smokers, and (b) the *suitability* and *capacity* of primary care to target effectively.

#### **9.3.1.1. Primary care priorities**

Pound *et al.* (2005) reported that in 2001, smoking cessation co-ordinators in England perceived young people to be the lowest priority, with patients with smoking-related illness being prioritised over-and-above this group. There was a strong ethical argument posed by interviewees in this PhD research around prioritising the target groups (not just young people) over those presenting with medical conditions. The central argument appeared to be the difficulty in weighing up the immediate quality of life benefits of quitting smoking in 'ill' patients, with the

long-term preventative effects of quitting in young people, and/or those not presenting with illness. This raises the issue of the place of primary and secondary prevention efforts in the primary care setting. The *medical model* of health promotion is focussed on reducing and/or preventing disease and mortality amongst the population at large, or high-risk groups through medical intervention (Naidoo & Wills, 2000). Whereas 'primary prevention' is associated with preventing the onset of disease/illness through the likes of providing lifestyle advice, 'secondary prevention' focuses on preventing the progression of disease/illness through effective treatment/intervention (Naidoo & Wills, 2000). Section 9.2 discussed the professional differences in role perceptions regarding primary and secondary prevention efforts within the primary care team. However, findings from this study would also suggest that the issue of 'targeting' was couched within this broader primary/secondary prevention framework.

Smoking cessation was commonly discussed within the context of chronic disease management (CDM), and it was regarded as an important intervention for preventing the progression of a range of chronic health conditions. The role of smoking cessation in CDM was also considered in light of local LHCC priorities. For instance, one LHCC chose to prioritise, amongst others, those patients with Diabetes and COPD. Taking together the ethical arguments around prioritising certain groups over 'ill' smokers, and the importance attached to the role of smoking in CDM, it was clear that smoking cessation was often couched within a broader secondary prevention framework. The importance attached to prioritising 'ill' smokers within a CDM framework, was perhaps an inevitable consequence of the development of services within a setting (primary care) where patients commonly present with medical problems requiring treatment/intervention.

#### ***9.3.1.2. Suitability and Capacity of primary care***

In addition to the tendency for ill smokers to be prioritised, there was also the issue of perceived *suitability* and *capacity* of primary care for targeting the priority groups. With regards to the suitability of primary care, it was perceived to be inappropriate for targeting young people in particular. Raw *et al.* (2005) highlighted that

alternative strategies were perceived to be required for reaching young people in England. Within the Health Board under study in this research, a similar sentiment was expressed. There was a reported lack of demand from young people, which was attributed to the inappropriateness of primary care as a setting for targeting this group. Many interviewees instead argued that schools and other community setting would be much more appropriate. Many perceived that a *prevention* approach should be adopted for targeting young people. Specifically, through targeting young people at an early age through schools and education, it was argued that this might be an effective means of preventing smoking uptake. The prevention approach, particularly regarding young people, has indeed been endorsed as playing a key role in a national tobacco control strategy (NHS Health Scotland & ASH Scotland, 2003).

The capacity of primary care to actively target the priority groups was another perceived problem. As discussed in chapter seven (Strategy Interpretation), the funding for the development of smoking cessation services within the Health Board was allocated predominantly to primary care. Across the board, the level of funding for the development of local smoking cessation services within primary was considered largely insufficient. As a result of this, services were perceived to be delivered at a very basic level. The development of more intensive services to target the three priority groups was commonly perceived to be beyond the capacity of local services. Consequently, services tended not to be proactive in *seeking* smokers from these groups, and instead offered services to those smokers who *presented* themselves for smoking cessation support.

However, with regards to young people and pregnant women, there was a reported lack of demand from these groups. Although many service providers proposed that pregnant women would be prioritised over other smokers, there were reported to be few referrals for pregnant women. Respondent discussion around the targeting of pregnant smokers was very much centred on the role of midwives. It was commonly perceived that midwives should be more focussed on targeting this group, although there were perceived to be few referrals from these health professionals. Similar to the experiences of service development in HAZs in England (Adams *et al.*, 2000),

there were reported difficulties in engaging with the midwifery profession in the early stages of service development within the Health Board. This was reported to be due to a lack of time to undertake training and the changing midwifery role. The updated smoking cessation guidelines for Scotland (Health Scotland & ASH Scotland, 2004) have, however, reinforced the requirement for smoking cessation co-ordinators to engage with midwives, and develop local strategies for targeting pregnant women.

Adams *et al.* (2000) reported perceived difficulties with targeting pregnant women through cessation services, including a lack of NRT entitlement. At the time of conducting this PhD research, NRT was in the process of becoming available for use with pregnant women, and therefore this was not reported to be a barrier to supporting pregnant women. However, given the strong ethical debate that had preceded the availability of NRT to pregnant women, it is surprising that there was little discussion amongst service providers around the ethical considerations of providing NRT to this group. However, one key ethical issue that *was* raised related the perceived victimisation of pregnant women by targeting them during pregnancy. There was particular concern that focussing on the potential damaging effects of smoking on the foetus (especially if quit attempts were unsuccessful) would induce feelings of guilt amongst such women. Health promotion efforts focused on individual behaviour change have been criticised for leading to victim-blaming (Naidoo & Wills, 2000). The strong ethical concerns around smoking cessation interventions during pregnancy, therefore, was one key factor underpinning the willingness of health professionals to intervene with this group of smokers, which had implications for service provision.

Although there were reported difficulties in attracting young people and pregnant women to services, there appeared to be less perceived difficulty in attracting smokers from low-income groups. However, rather than pro-active targeting of this group, targeting appeared to occur on a passive basis. As was found to be the case in England (Pound *et al.*, 2005), it was common for interviewees to report that smoking cessation services were located in low-income areas, in order to increase accessibility



of services for this group. Several interviewees discussed the need to ensure that services were accessible to low-income groups, and indeed with some services, an effort was made to locate services in community venues, or locally accessible venues. However, in order for smoking cessation services to be effective in reducing smoking prevalence amongst low-income groups, reach must be accompanied by successful quitting (Chesterman *et al.*, 2005). Besides ensuring that services were accessible, there was limited discussion of the extra support that low-income groups would require. Several interviewees expressed frustration at the lack of funding allocated to services beyond primary care (e.g. community groups), for the development of services to target young people and low-income groups. There was recognition of the extra support required for targeting these groups, which will be discussed in the following section.

### **9.3.2. Cessation services as an Intervention**

Interpretation and implementation of the NHS smoking cessation strategy appeared to be couched within understandings of (a) wider health promotion frameworks, and (b) motivational assessment.

#### ***9.3.2.1. Wider Health Promotion Frameworks***

One key characteristic of the smoking cessation strategy discussed by interviewees, was its 'traditional' approach to health promotion, whereby responsibility to adopt a healthier lifestyle/change health behaviour is perceived to lie predominantly with the individual (Downie *et al.*, 1996; Caplan & Holland, 1990). One key criticism of 'traditional' approaches to health promotion, however, is that they neglect wider influences upon health (Downie *et al.*, 1996). Many interviewees, in both a strategic *and* service delivery role, advocated a social change model of health promotion, which focuses on the broader social and political factors affecting health/health behaviours in the wider population (Naidoo & Wills, 2000). The argument that smoking cessation strategies should move beyond focusing solely on individual cessation, was particularly prominent with regards to tackling smoking amongst low-income groups.

In relation to low-income groups some respondents argued that the NHS smoking cessation strategy was misguided in its approach to tackling smoking. This argument was presented more by those people who had a working background with low-income groups, and/or practitioners who worked in low-income areas. Qualitative research with smokers in disadvantaged areas, has indicated that smoking behaviour is influenced by the circumstances associated with socio-economic deprivation (Bancroft *et al.*, 2003). Additionally, research suggests that tobacco control strategies should address both nicotine dependence *and* the material difficulties facing smokers in low-income groups (Wiltshire *et al.*, 2003). As discussed previously, victim-blaming has been highlighted as one key ethical issue associated with traditional/behaviour change approaches to health promotion, given the focus on individual responsibility for behaviour change (Naidoo & Wills, 2000). Several interviewees described how they were uncomfortable with the emphasis of the cessation services on individual behaviour change, particularly due to the fact that it neglected the wider structural influences upon health. In particular, several interviewees presented a strong ethical argument about the need to understand the role smoking played in peoples' lives, and the structural (social/economic) barriers that may influence cessation.

There appeared to be different understandings about how to target low-income groups. For instance, one area of contention was how long NRT should be made available to patients. Although discussion around NRT was often couched within the issues of budget control, it was clear that there were also different understandings of the social/financial framework of smoking behaviour in low-income groups. For example, on the one hand there were those who argued that smokers should buy their NRT with the savings they made from quitting smoking. However, there were those who clearly refuted this argument. One interviewee who worked with low-income groups, for instance, said that many of his clients bought tobacco via the black market, which was significantly cheaper. Indeed, research has indicated that cigarette and tobacco smuggling can play a significant part in the lives of low-income smokers, struggling to deal with the increasing costs of cigarettes (Wiltshire *et al.*, 2001).

It has been suggested that low-income smokers require more intensive support to help them quit (Health Scotland & ASH Scotland, 2004). The type of support that was on offer within LHCCs suggested that there were different perceptions of the needs of low-income groups. Several interviewees discussed the need to make services accessible by running group support in local venues such as community centres or SIP (Social Inclusion Partnership) offices. One LHCC co-ordinator also discussed that smoking cessation groups within her LHCC adopted a 'holistic' approach to smoking cessation, by addressing issues other than smoking. For instance, the co-ordinator discussed that a dietician was involved in the group support, in order to provide advice about 'eating on a budget'. However, the argument from another LHCC co-ordinator that "*low-income groups get their fair whack at it*", suggests a very different understanding of the needs of low-income groups. There were, therefore, different perceptions around the most effective strategies required to target low-income groups, which impacted upon service provision.

There is currently considerable activity around the piloting and evaluation of a range of different interventions for different populations of smokers in Scotland. For instance, NHS Health Scotland and ASH Scotland have initiated a programme of eight pilot programmes aimed at young people, in order to establish best practice around smoking cessation interventions (NHS Health Scotland & ASH Scotland, 2003). Additionally, Partnership Action on Tobacco and Health (PATH) are currently in the process of evaluating ten pilot projects across Scotland, aimed at different populations of smokers (including the three target groups). There is a therefore a (potentially) promising evidence-base developing around 'best practice' interventions for various groups of smokers. It will be important that this evidence feeds into the development of smoking cessation services across Scotland. Additionally, this study highlighted that health professionals tended to perceive smoking cessation as an 'isolated' intervention to tackle smoking. However, as outlined by the tobacco control action plan for Scotland (Scottish Executive, 2004), smoking cessation services are part of a wider national tobacco control initiative. In the updated smoking cessation guidelines for Scotland (Health Scotland & ASH

Scotland, 2004), it was stated that cessation services “compliment” wider fiscal and legislative interventions. It may be important, therefore, to ensure that health professionals providing smoking cessation interventions are made aware of the role of such interventions within the wider national tobacco control framework.

#### **9.3.2.2. *Motivational Assessment***

The role of patient *motivation* in the cessation process was one that appeared to inform decisions around service delivery, as well as recommendations for future service development. One significant impact of perceptions around motivational processes, was the way in which three LHCCs in particular managed waiting lists for smoking cessation support. In LHCCs ‘C’, ‘D’, and ‘F’, a high threshold service was developed, whereby measures were introduced to get the most motivated smokers into services. Within these high threshold services, ‘motivational assessment’ interventions were introduced in order to ‘weed out’ the least motivated smokers. The motivational assessment procedure included information evenings, motivational interviews, and a correspondence process in which smokers were required to demonstrate their intention to receive smoking cessation support. ‘Motivational assessment’ appeared to be underpinned by the increasing demand for services, and the need to reduce waiting lists effectively. It was perceived that those smokers who were ‘weeded out’, were the least motivated smokers. However, in discussing the motivational assessment procedure, there was little reference made to the barriers that may prevent smokers from initiating the smoking cessation process, including access to services, and the wider structural issues discussed previously. In LHCC ‘G’, this ‘motivational assessment’ approach was perceived to be incompatible with the local ‘philosophy’ of making services as freely and easily accessible as possible. This LHCC was particularly concerned with reaching low-income groups, and a high threshold approach was perceived to exclude many smokers from accessing services. Consequently, LHCC G opted for a low-threshold service, in order to ensure maximum availability to patients.

The above discussion has raised the issue of differences between smokers who access cessation support services. Indeed a reported limitation of the NHS smoking

cessation strategy, discussed by respondents, was its focus upon ‘motivated’ smokers. Health promotion strategies based on The Stages of Change (SOC) framework have been criticised for placing the responsibility for behaviour change on the motivational status of the individual, whilst neglecting the wider structural influences upon health (Bunton *et al.*, 2000)<sup>1</sup>. Bunton *et al.* (2000) highlighted the limitation of the SOC approach in neglecting the needs of *unmotivated* individuals. Indeed, several interviewees discussed the requirement to tap into the needs of those smokers not reached by the NHS smoking cessation strategy.

Once *engaged* with the service, however, it was proposed that services could improve efficiency in supporting patients through the quitting process. The provision of a *flexible* smoking cessation service was perceived as key in achieving this. By ‘flexible’, it was recognised that when patients presented for support, they should be seen straight away, as opposed to waiting several months on a waiting list. Additionally, it was recognised that the standard 6 weeks of support could be insufficient, and that patients may require support beyond this point. The three-month stage (post-quit date) was perceived to be critical as a potential point of relapse, particularly given the reduction in pharmacological support at this stage. In LHCC ‘D’, this underpinned the decision to provide a twelve-week program, as opposed to the standard six weeks. Several interviewees also discussed the potential benefit of informal follow-up support, in order to help patients maintain successful quitting. However, inadequate resources appeared to be a key barrier to offering this in practice. One perceived opportunity for intervention, however, was the three month (or six and twelve months) follow-up conducted by the Health Board. Many interviewees appeared to disagree with the ‘bean-counting’ nature of the monitoring procedure, and argued that it could be used as a way of re-engaging with smokers who may have relapsed.

In their recommendations for the future of Scottish smoking cessation services, PATH (2003) suggested a more structured monitoring of services across the country.

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<sup>1</sup> There have also been recent criticisms of the model regarding its usefulness in understanding and predicting health behaviour change, signalling a potential divergence from this approach in developing behaviour change interventions (West, 2005).

As part of the co-ordinated smoking cessation team, it was recommended that ‘smoking cessation officers’ be employed to conduct the 3 and 12-month follow-ups. It was suggested that these follow-ups (3 month in particular) also be regarded as “*clinical interventions*” (p.26), thereby acting as a resource for those patients who may have relapsed. PATH (2003) also recommended that local smoking cessation services collect information on those smokers who were not successful quitters, but had “*made positive changes in their tobacco use*” (p.11) (i.e. reduced the number of cigarettes smoked). Recognition of the positive impact of interventions, irrespective of whether smokers had quit or not, was perceived to be important by health professionals in this research, and by health professionals offering smoking cessation support in English services (Adams *et al.*, 2000).

The PATH recommendations, therefore, address two areas of concern that interviewees had with the monitoring system in place within the Health Board. It is too early to determine the impact of these recommendations, and whether they will be implemented in practice. However, it is likely that, if implemented, they will contribute to improving the smoking cessation intervention process for patients, and reflecting the wider impact of interventions on smoking behaviour.

## **9.4. Key Factors underpinning Service Development**

This section will discuss four over-arching issues that appeared to be key factors in shaping the process of smoking cessation service development and delivery within the LHCCs.

### **9.4.1. Demand-led service development (Zyban and NRT)**

Pharmacological support was a integral component/ ‘characteristic’ of the NHS smoking cessation strategy, which played a key role in the service development process. Abelson’s (2001) research on the role of context on local healthcare decision-making, highlighted the impact of ‘precipitating influences’ in *mobilising* action and change. Specifically, Abelson’s research found that one particular ‘precipitant’, the threat of hospital closures’, acted to ‘mobilise’ local communities into establishing an active campaign against such closures. With regards to the



smoking cessation services, it was clear that within the Health Board under study, one key ‘precipitant’ to mobilising action around service development was Zyban becoming available on prescription in June 2000. The impact of Zyban on service development within this Health Board, however, appears not to be an isolated effect. The evaluation of the smoking cessation services in England found that Zyban in particular impacted upon demand for specialist support services, which played a significant part in the service development process in the early stages (Bauld *et al.*, 2005).

As outlined in chapter five (Service Development and LHCC Capacity), a considerable degree of uncertainty was perceived around the direction in which the smoking cessation services would develop within the Health Board. However, when Zyban became available on prescription, this was perceived as the major catalyst underpinning the development of smoking cessation services within a primary care framework. Similar to the experiences of service development in England (Bauld *et al.*, 2005), this was perceived to be underpinned by (a) an increased public demand for the drug on prescription, and (b) the requirement for GPs to have a support structure (i.e. specialist support services) in place for prescribing the drug. Zyban received considerable publicity as a new ‘anti-smoking’ drug on the market, although, it was advocated that it should only be prescribed alongside intensive smoking cessation support. The high public demand for the drug, and the requirement for specialist support as an adjunct, were perceived to be key in driving the development of local services within primary care.

In terms of the impact of NRT, one interviewee discussed concern amongst GPs within her practice that the availability of NRT on prescription might encourage patients to consult repeatedly for different forms of NRT. The perceived need to limit possible repeat consulting/prescribing, in turn, informed the development of smoking cessation groups within this practice. Several interviewees discussed the increased interest in smoking cessation that NRT generated amongst patients, and the positive aspect of being able to ‘offer’ patients something to support their cessation process.

The impact of NRT on prescription, however, did not appear to have the same level of impact on service development as Zyban.

Smoking cessation services are now in their fifth/sixth year of development in the UK. The impact of Zyban and NRT, therefore, on driving smoking cessation service development will have reduced considerably. However, in the formative years of service development, Zyban becoming available on NHS prescription (and NRT to a lesser extent), had a significant impact on the progression of service development within primary care. Given the impact of Zyban (and NRT to an extent) in driving service development within primary care, it is valuable to consider how service development might have progressed in the absence of this key precipitant. There was clearly perceived to be a reticence amongst GPs with regards to their smoking role, as discussed in section 9.2.1. of this chapter. Therefore, without the influence of Zyban in bringing the focus of smoking cessation into General Practice, it is likely that service development within primary care would have been a much more difficult process, with potentially greater barriers to overcome. Indeed, Adams *et al.* (2000) highlighted the difficulties involved in engaging with General Practice, and the protracted process of service development in 1999/2000, which was prior to NRT and Zyban becoming available on prescription. It is also possible, that without the influence of Zyban, services may have been encouraged to develop outwith the primary care setting. For instance, it is perhaps more likely that funding may have been allocated to other agencies (e.g. community groups) in order to target the three priority groups outlined in *Smoking Kills*.

#### **9.4.2. Key people**

A second key factor underpinning the development and delivery of smoking cessation services within the LHCCs, was the role of key people. As discussed in chapter six (Personal and Professional Commitment), one of the primary motivations underpinning staff involvement appeared to be interest in, and enthusiasm for, smoking cessation. This spanned all levels of service involvement, from those in a co-ordinating role, to those staff providing the intensive smoking cessation support. That is not to say, however, that there was an equal level of enthusiasm and interest

from all staff identified in these roles, and staff exerted a varying degree of involvement and influence. However, what was clear from the interviews was that key motivated staff, across all levels of service involvement, played a pivotal role in the service development and delivery process.

Pettigrew *et al.*'s (1992) research around strategic change in the NHS, identified 'receptive contexts for change'. The availability of *key people leading change*, was identified as one of the key factors facilitating successful change in District Health Authorities. Indeed, it was stated that "*an important factor which makes change highly contextually sensitive is the availability of key people in critical posts leading change*" (Pettigrew *et al.*, 1992, p.278). Importantly, Pettigrew *et al.*'s research highlighted that *key people* were not necessarily defined by their rank or status within an organisation. Instead, personalities and personal skills were often found to precipitate their role in the change process. Additionally, they concluded that, in the change process, "*it was a 'critical mass' of 'enthusiasts' with shared values that was important, rather than one individual champion of change*" (p.279).

When reflecting upon the process of service development within the LHCCs, Pettigrew *et al.*'s concept of 'key people leading change' is particularly relevant. To reiterate, enthusiasm and interest of staff in various roles (e.g. co-ordinators; smoking cessation support providers), provided a significant momentum for smoking cessation service development. In a few LHCCs, 'non-traditional' staff members such as a pharmacist and health visitor undertook the co-ordinating role. It was clear that this was underpinned by a personal enthusiasm for smoking cessation and strong desire to drive local smoking cessation services forward. This personal commitment was perceived to provide a crucial momentum for service development within these LHCCs.

Research has indicated that 'opinion leaders' can have a positive (or negative) impact on the diffusion of innovations/new working practices (Fitzgerald *et al.*, 2003; Locock *et al.*, 2001; Fairhurst & Huby, 1998). It has been proposed that the diffusion process within healthcare settings is underpinned by social and interactive processes,

with the exchange of information within professional networks (Fitzgerald *et al.*, 2003). With regards to the role of key people in this 'interactive' process, Locock *et al.* (2002) have distinguished between the '*expert*' opinion leader (credible authority who provides the professional/expert authority for the diffusion of an innovation), and the '*peer*' opinion leader (influence diffusion by being a source of reference for their peer group).

It was clear that the role of several of those key people who undertook the co-ordinating role within the LHCCs, reflected that of '*expert*' and/or '*peer*' opinion leaders. For instance, in LHCC 'D', it was a pharmacist who undertook the role of smoking cessation co-ordinator within the LHCC. In the early stages of service development, it was primarily pharmacists who undertook smoking cessation support within the LHCC, suggesting that a '*professional*' peer process was at play. In LHCC 'G', the Tobacco Issues worker, as well as the cardiac nurse, had worked to establish awareness of tobacco issues, and smoking cessation, prior to and around the time of the White Paper. As a result of this work, strong relationships had been forged between these staff members and other staff members within the LHCC. They, therefore, appeared to undertake the role of *expert* and *peer* opinion leaders. That is, they were perceived as a '*credible*' source of reference by peers within the LHCC with regard to tobacco issues and smoking cessation.

Enthusiasm and commitment at various levels of service involvement were key factors in smoking cessation service development and delivery within the LHCCs. Where there were '*pockets*' of activity within LHCCs, this was often attributed to a lack of staff interest in undertaking smoking cessation support. Interviewees in a co-ordinating role often reflected upon the pivotal role of '*on the ground*' staff in underpinning the development and delivery of the local services. Such staff were commonly perceived to be the key link between the service as a '*concept*' and it being rolled-put in practice. It was clear therefore that service development depended upon the support, commitment, enthusiasm, and direction from staff in various roles.

### 9.4.3. Service Co-ordination and Management

It was clear from interviewing staff from several different LHCCs, that a key factor underpinning service delivery was an effective system of local service co-ordination and management. In the evaluation of smoking cessation services in Health Action Zones in England (Adams *et al.*, 2000), the role of the smoking cessation co-ordinator within Health Authorities was perceived to be crucial in the effective development of local services. It was highlighted that the co-ordinator acted as a dedicated resource to raise the profile of smoking cessation locally and to provide support in training and staff recruitment. Within the Health Board under study in this research, there were two central smoking cessation co-ordinators based at the Health Board, addressing the wider structural issues around service development within the Health Board area (i.e. funding; training; monitoring). Interviewees, however, tended not to discuss in depth the role and impact of these central co-ordinators on local service development. Instead, the focus on the effective *local* co-ordination was prominent, likely given the semi-autonomous nature of LHCCs in developing local services.

Within all but one of the LHCCs involved in this research, some form of local co-ordination system had been established. There appeared to be two key aspects of this co-ordination system. The first aspect was the requirement to have a method of managing the clerical/administrative side of service delivery. In LHCCs that had opted for a combination approach to service delivery, clerical/administrative support was perceived to be crucial in managing and co-ordinating referrals from various practices throughout the LHCC, particularly as demand for services increased. In such cases, administrative/clerical support workers were employed to provide support. For those practices operating at a practice-based level, the administrative efforts appeared to be much easier to co-ordinate, given the 'in-house' nature of service delivery.

The second key aspect of local service co-ordination, was an apparent necessity for someone to 'take the reins' of local LHCC services. Respondents clearly perceived the need for services to have, in a sense, a 'focal point' for service management, and

in most LHCCs, one or two key people appeared to emerge as local service ‘co-ordinators’. The type of professional undertaking this role varied, as well as their ‘function’ as co-ordinators. For instance, in LHCC ‘C’, the service ‘co-ordinator’ was a retired nurse employed on a part-time basis, who co-ordinated the referrals, carried out the motivational interviews within the LHCC, and provided group support. In LHCC ‘E’, however, the ‘co-ordinator’ simply acted as a central source of contact for health professionals and arranged quarterly feedback meetings.

There was a clear requirement for someone to take charge of service development within the LHCCs. In two LHCCs, the formation of a smoking cessation ‘sub-group’, was also perceived to be beneficial in informing and directing the development of local services. The detrimental impact of not having a local system of co-ordination was demonstrated by the experiences of LHCC ‘A’, where interviewees described a lack of local management and co-ordination of services. One of the factors perceived by respondents to contribute to this lack of co-ordination was the geographical layout of the LHCC, in that it consisted of both rural and urban areas. Bauld *et al.* (2005) reported that service development was informed by the specific geographic/structural make-up of local areas. In particular, the difficulties experienced in co-ordinating group support within rural areas, informed the provision of one-to-one support as the predominant method of service delivery (Bauld *et al.*, 2005). One of the factors perceived by respondents in LHCC ‘A’ to contribute to a lack of service co-ordination was the geographical layout of the LHCC. That is, it consisted of both rural and urban areas, and it proved difficult to establish a co-ordinated service locally. This LHCC therefore opted for a practice-based approach to smoking cessation, given the geographic spread of the LHCC. However, respondents from this LHCC perceived that the lack of local co-ordination rendered the influencing of service development within local Practices, problematic. As a result, there was uncertainty around the extent of smoking cessation activity within the LHCC.

Local co-ordination of services was therefore a key factor in the development and delivery of services within the LHCCs. It is encouraging, therefore, that PATH



guidance (PATH, 2003) and the updated smoking cessation guidelines for Scotland (HEBS & ASH Scotland, 2004) have recommended the establishment of a more structured system of co-ordination for Scottish smoking cessation services. Following a mapping exercise of smoking cessation services in Scotland, PATH (2003) recommended that dedicated staff be recruited to manage services. It has been proposed that one or more smoking cessation services be established within each Health Board area, with each service serving a population of approximately 250,000. There are roughly half-a-million of a population in the Health Board under study in this research, suggesting that two or more services may have to be established if these recommendations come into force. It has also been recommended by PATH (2003) that one or more smoking cessation co-ordinators be employed at the Health Board level, depending on the number of 'smoking cessation services' required locally.

The role of the co-ordinators, outlined by PATH (2003), appears to reflect that of the current co-ordinators based in Scottish Health Boards (i.e. overseeing service development, strategies, training, publicity, and a point of contact between health professionals/other organisations and the Health Board). However, one fundamental difference is the recommendation for the creation of several services within one health board area, with each having its own dedicated co-ordinator. Services are currently in state of change at the moment in Scotland, and it is unknown how this will roll out in practice. However, the experiences of those LHCCs involved in this research would suggest that the co-ordination of services at a more localised level would be beneficial. It may act to 'focus' efforts on the local development of smoking cessation services, particularly in areas where there is a lack of local ownership of services, as was the experience in LHCC 'A'.

The updated smoking cessation guidelines for Scotland (Health Scotland & ASH Scotland, 2004) also indicated that smoking cessation services organised at the individual practice level should be provided within a wider 'core' support structure, given the evidence of the ineffectiveness of such services outwith this structure. The findings from this study suggest that smoking cessation support provided on a

practice basis had many perceived benefits. For instance, it was described as easier to co-ordinate in-house referrals and to find accommodation. In addition, it was perceived as enabling a closer relationship between the patient and the support provider. However, one of the issues raised by several respondents was the difficulty in managing, and influencing, the smoking cessation activity that was carried out at the practice-level within LHCCs. Quite often this lack of influence was attributed to the limited funding available for services, and hence the need for services to be provided on a 'goodwill' basis. One respondent proposed that each practice should have a smoking cessation 'link' person, to link practice activity with the central LHCC service, and raise the profile and effectiveness of smoking cessation activity within the practice. This respondent argued that it was hard to control what happens in Practices. The recommendation that practice-based services be provided within a wider co-ordinated support structure, therefore, reflects many of the experiences of service provision on a practice basis within this study.

However, this research also highlights that it is crucial to account for contextual influences upon service provision. LHCC 'E' developed services on a practice-basis with minimal co-ordination. This LHCC had a working history of operating on a practice-basis, which appeared to underpin much of the success in establishing smoking cessation services within each practice in the LHCC. Additionally, LHCC 'A', had experienced difficulty in establishing a co-ordinated services, although a couple of local Practices (one in particular was represented in this research), were reported to have developed efficient smoking cessation services. The experiences of these LHCCs, therefore, suggest that local LHCC and Practice context/ 'ways of working', are important factors to consider in the implementation of a strategy to support the development of smoking cessation services.

PATH (2003), and the updated smoking cessation guidelines (Health Scotland & ASH Scotland, 2004) have also recommended the appointment of a dedicated administrative/clerical worker to each smoking cessation service. The guidelines did not stipulate the precise role or remit of such staff (e.g. co-ordinate referrals). However, given the importance attributed to clerical support by interviewees,

particularly in LHCCs that had opted to provide centralised group support, this would likely be a valuable addition to a smoking cessation service.

The PATH mapping exercise (PATH, 2003) highlighted that services throughout Scotland were perceived to be under-resourced, and understaffed. Therefore, the report stipulated that additional funding would be required to instigate the staffing recommendations outlined above. As discussed previously, and outlined in Appendix nine, the Scottish smoking cessation services have received increased funding. Smoking cessation services in Scotland have been in a continuous state of change since the *Smoking Kills* funding was first allocated in 1999. In light of updated guidelines, recommendations, and additional funding of services, this process of change will continue. Additionally, the abolition of LHCCs is due to occur, with the imminent introduction of Community Health Partnerships (CHPs). It is unknown at this stage how CHPs will affect local service structure within Health Boards. PATH's (2003) recommendations for a more structured system of local service co-ordination have the potential to improve the efficiency of smoking cessation services across Health Boards in Scotland (and certainly reflect what is happening in practice). However, it is perhaps too early to predict with certainty the precise impact of these recommendations.

#### **9.4.4. Prioritisation of smoking cessation**

Policy implementation literature has indicated that the policy process is not necessarily a linear one, and that despite policies/strategies being advocated nationally, they may be interpreted and implemented differently at the local level. The '*implementation gap*' is a term that has been used to denote this local interpretation of national policy (Exworthy *et al.*, 2002). Research has indicated that the way in which national policy is *perceived* at the local level, can affect policy implementation (Exworthy *et al.*, 2002). When considering the implementation of the smoking cessation services within the Health Board under study, it was clear that one of the key factors mediating interpretation and implementation of the strategy was the perceived, and actual, *priority* assigned to smoking cessation as a national health strategy.

In terms of the perceived priority assigned to smoking cessation, *funding* was clearly one of the key indicators of the importance attached to smoking cessation by The Scottish Executive. Pettigrew *et al.* (1992) referred to the influence of the ‘outer context’ in affecting the process of change in healthcare organisations. This *outer context* refers to the wider political and economic climate. The national ‘political scene’ appeared to be particularly important in influencing perceptions of smoking cessation as a national health priority. Specifically, there was a common sentiment that smoking cessation, as a national strategy, was not as high on the political agenda as it outwardly proposed to be. Additionally, there was perceived to be a lack of political will to make smoking cessation more of an issue on the national health agenda. Discussions around funding were couched within the perceived inadequacy of the funding with particular regard to (a) the funding and perceived priority assigned to other health issues, and (b) the development of comprehensive services locally. The priority assigned to smoking cessation was often compared to the funding allocated for the development of other health strategies, such as those to tackle drugs and sexual health. Consequently, the increased funding to other health strategies appeared to render smoking cessation less of a perceived priority.

Research has indicated that particular health strategies may be relegated in light of other more pressing national strategies (Exworthy *et al.*, 2002). Although it was proposed that *Smoking Kills* had raised the profile of smoking cessation on the political agenda, the trend for ‘new’ strategies/priorities to come onto the health agenda, meant that smoking cessation was perceived as having to compete with these new strategies. It was recognised that other health issues/strategies also required funding and prioritisation, although it was proposed that this rendered smoking cessation less of a priority. The fact that the importance attached to smoking cessation was perceived to diminish over time, was also a source of frustration, particularly given the comparative level of morbidity and mortality associated with smoking, and the link between smoking and many chronic diseases.

Research has indicated that national policy may be perceived differently at the local level, and that policy that is promoted centrally may not be compatible with what can be achieved locally (Exworthy *et al.*, 2002). Indeed, this study highlighted that the perceived discrepancy between the priority assigned to smoking cessation nationally by government, and the funding allocated for the development of comprehensive services locally, was a significant source of contention. The comment by one interviewee that The Scottish Executive “*should put their money where their mouth is*” was a common sentiment. The level of funding was generally perceived to be inadequate for services to develop beyond a ‘basic’ level, and to effectively target the three priority groups. Besides the level of funding allocated, one of the key problems around funding was a lack of certainty around whether the funding would be recurring or not. In particular, interviewees discussed the difficulties in employing staff on short-term contracts, and the inability to plan the development of local services amidst such uncertainty. Such difficulties and frustrations associated with short-term funding were similarly experienced in the development of smoking cessation services in England (Bauld *et al.*, 2005).

As outlined in Appendix nine, the one million pounds per annum, allocated for the ring-fenced period 1999-2002, became part of Health Boards’ unified budgets, and therefore continued to be available. Additionally, from 2001/02, one million per annum was allocated via the Health Improvement Fund, with some of this money to be targeted at smoking cessation services. Again, this HIF funding was integrated into Health Boards’ unified budgets. However, although this funding was available for smoking cessation services within the Health Board’s unified budget, this did not appear to have been successfully translated to those staff ‘on the ground’ within LHCCs. Instead, there was a high degree of uncertainty around the recurring nature of the funding, and how much would be available if it *was* indeed recurring.

This uncertainty ‘on the ground’ may reflect the degree of autonomy that Health Boards have over the interpretation and implementation of national policies. It has been argued that the ‘hollowing-out’ of the NHS structure (Jessop, 1994), has resulted in a more complex policy implementation path between Central Government

and local agencies. Health Boards, as semi-autonomous organisations, therefore have a degree of influence over the implementation of national policy. Indeed, with regards to the HIF funding, one interviewee in a strategic role argued that there was a discrepancy between what was advocated nationally by The Scottish Executive, and how Health Boards prioritised this HIF funding for smoking cessation at the local level. It was interesting that very few interviewees discussed the HIF funding available for the development of local services. In two LHCCs respondents indicated that HIF funding had been used to employ a dedicated smoking cessation support provider. However, respondents from other LHCCs did not discuss HIF funding allocations, thus suggesting that some LHCCs may not have been prioritising smoking cessation with this funding.

A perceived lack of allocation of HIF funding for smoking cessation could have been attributed to the perceived priority assigned to smoking cessation, by The Scottish Executive, at the Health Board level. Indeed, one interviewee discussed that smoking cessation did not feature prominently in the Health Board's Local Health Plan. The Local Health Plan outlines Health Board priorities, which ultimately reflects *national* priorities. Given that smoking cessation did not feature prominently, it was argued that this reflected a perceived lack of prioritisation of smoking cessation by The Scottish Executive. Indeed, given previous discussion of the perceived priority assigned to other health issues, and the comparatively low level of funding ear-marked for smoking cessation, this may have rendered smoking cessation less of a priority at the Health Board level.

However, beyond the Health Board, smoking cessation was also prioritised differently at the LHCC level. As discussed in chapter five (Service Development and LHCC Capacity), the status of smoking cessation on LHCC agendas was also perceived to impact upon service development. Although all LHCCs developed some form of smoking cessation service, the prioritisation of smoking cessation at management level within the LHCCs was perceived as being particularly important in facilitating the development of services locally. Two LHCCs in particular had identified smoking cessation as a local priority. In LHCC 'B', smoking cessation



was identified as one of the five priority areas on the public health forum, and had a close working relationship with the Health Board. Both of these factors were described as advancing service development, through LHCC 'G' had prioritised smoking cessation as a key issue locally, prior to the publication of *Smoking Kills*. A substantial amount of background work in raising the profile of tobacco issues locally, engaging with GPs, and in establishing early smoking cessation services, were perceived to facilitate the development of smoking cessation services once the White Paper funding became available. Additionally, key support from LHCC management, and other authoritative bodies within the LHCC, was perceived to ensure the continued commitment to tobacco control issues, and smoking cessation services locally.

Given previous discussion on the perceived priority of smoking cessation nationally, and at the Health Board, it is likely that this may also have had an impact on local perceptions of the priority that should be assigned to smoking cessation. The interviews for this thesis were conducted between November 2002 and April 2003. As can be seen from Appendix nine, the funding available to smoking cessation services at this point included the Smoking Kills and HIF funding, that was part of the Board's unified budget. However, from 2003, smoking cessation, and tobacco control issues more generally, gained an increasing profile on the political agenda. In September 2003, guidance from The Scottish Executive indicated that an additional one million pounds would be available for smoking cessation services for 2003/04 (The Scottish Executive, 2003b). This additional one million was subsequently made available for 2004/05 and 2005/06, in addition to an indication of a further four million being made available in 2005/06 (The Scottish Executive, 2004c). This additional four million pounds was assigned for the development of smoking cessation services following the publication of The Scottish Executive's Tobacco Control Action Plan in 2004 (The Scottish Executive, 2004b). This Action Plan raised the profile of smoking cessation services, and backed further financial commitment to smoking cessation services within a wider tobacco control strategy. As outlined in Appendix nine, this financial commitment to smoking cessation services will continue until at least 2007/08, with an additional two million per

annum being allocated from 2006/07. The yearly funding allocation for the development of smoking cessation services has, therefore, increased from the original £3 million outlined in *Smoking Kills* (for the period 1999/00- 2001/02) to £11 million in 2007/08.

The Scottish Executive (The Scottish Executive, 2004b) also outlined plans for introducing targets for Scottish smoking cessation services. Exworthy *et al.* (2002) proposed that the way in which health strategies are performance managed, indicates their relative priority on the national *and* local political agenda. Indeed, in discussions around the priority assigned to smoking cessation, interviewees reflected upon the lack of targets assigned to smoking cessation, and the emphasis The Scottish Executive placed on meeting targets relating to other issues, such as diabetes, CHD, or waiting lists. However, new smoking cessation targets are in the process of being set for each Scottish Board (The Scottish Executive, 2004), which may act to increase the priority assigned to smoking cessation at the local LHCC level. It may be important, however, to consider the impact that target-setting had on the development of smoking cessation services in England. Research has indicated that priority is assigned to issues that are performance managed by central government (Exworthy *et al.*, 2002). The smoking cessation through-put targets set by the Department of Health had a detrimental impact on the development of services to meet the needs of the three priority groups in England, for which no specific targets had been set (Pound *et al.*, 2005). Although *national* health targets have been set for reducing smoking prevalence amongst these three groups, the English experience would suggest that it might be worth considering the introduction of *specific* cessation targets for each of the priority groups at the Health Board level.

It is not only the setting of targets that may impact upon the perceived priority of smoking cessation a national health strategy, but also the method by which services are monitored. There was a considerable degree of discontent around the monitoring of the smoking cessation services within the Health Board. First of all, the follow-up procedure was commonly perceived to be a time-consuming process, and there were perceived variations in the efficiency of the one-month follow-ups conducted by

health professionals providing intensive support. Secondly, there was general discontent with the quality of the feedback received from the Health Board. Consequently, the monitoring process was commonly perceived to be a redundant process, particularly in terms of improving/informing service delivery.

PATH (2003) highlighted that there was a considerable degree of variation in terms of how each Health Board audited local services, and therefore difficulty in establishing a broader picture of the success of Scottish services. The report outlined recommendations to improve the efficiency and quality of the monitoring process of smoking cessation services in Scotland. A minimum data set, required for use by all Scottish services, was outlined in this report, which is due to come into effect in 2005. Additionally, this monitoring data will be fed into a central database, with the information readily available to Scottish services. Given the improved monitoring of Scottish services, this may act to increase the perceived importance of smoking cessation services locally.

## **9.5. The case study and wider theoretical frameworks of the policy implementation process**

As proposed by Barrett (2004), *“there is more than ever a need to invest in studies of implementation and change processes, both conceptual and empirical; studies aimed at both understanding and explaining the dynamics of the policy-action relationship”* (p.260). The case study undertaken in this research has much to contribute in terms of understanding the process of implementing national policy at the local level and in highlighting key aspects of the ‘policy-action’ relationship.

In contextualising the research findings within the policy implementation literature, it is particularly useful to consider Exworthy & Powell’s (2004) framework of policy streams at this stage. As discussed in section 2.6.3., this model engenders the current shift towards a consideration of the confluence of policy across both vertical and horizontal dimensions. Exworthy & Powell (2004) proposed that successful strategy/policy implementation is more likely to occur when the three policy streams of *policy*, *process* and *resources* are aligned across three dimensions: central-local;

centre-centre; and local-local. Exworthy & Powell (2004) argue that “*failure to connect these streams at each level may lead claims that policies are rhetorical*” (p.269).

The findings from this research indeed suggest that a lack of confluence in the three policy streams in the ‘traditional’ vertical dimension, could engender the notion that the promotion of smoking cessation strategy as a national ‘priority’ by The Scottish Executive was ‘rhetorical’. The *resource* stream was particularly important in this regard, and was inextricably linked to the *policy* stream in terms of impacting upon the effective ‘transmission’ of policy goals to the local level. That is, despite The Scottish Executive rhetoric that smoking cessation was an important strategy, the perceived low level of funding allocated in comparison to other health strategies, (in addition to limited monitoring and performance management/targets) rendered smoking cessation less of a priority at the LHCC level. Additionally, uncertainty around the recurring nature of the smoking cessation funding also generated discord within the *resource* stream, and was perceived to generate difficulty for service sustainability.

With regards to the *process* stream (in the vertical dimension), the smoking cessation guidelines for Scotland (HEBS & ASH Scotland, 2001) provided a clear framework of how the services should be developed in practice, particularly within the primary care setting. However, the research suggested that, within this *process* stream, the feasibility of implementing this policy at the local level was compromised by two key factors. Firstly, linking in with the *resource* and *policy* streams, there were clearly perceived to be difficulties in delivering a smoking cessation service when faced with more pressing demands, and limited funding and staff time. Secondly, local interpretation of the strategy within the context of the perceived suitability of primary care and the limitations of a cessation approach, resulted in varied perceptions of how the services could/should best be delivered in practice.

In the vertical dimension, therefore, there was a distinct lack of confluence in the three policy streams, with the *resource* stream being a particular source of difficulty.

However, moving on to a consideration of the horizontal streams (Exworthy & Powell, 2004), there was also evidence of disjuncture in the policy streams at the *local-local* level. Within the *policy* stream, it was clear that there were differences between LHCCs with regards to how the smoking cessation strategy had been prioritised locally. This, in effect, resulted in considerable variation in the extent to which local services had been developed within the Health Board area. Variations in prioritisation (*policy* stream) also extended to the way in which smoking cessation funding was used at the local level (*resource* stream).

Exworthy & Powell (2004) contextualised their model within the framework of joined-up-government (JUG). In discussing policy streams at the *local-local* level, therefore, there was a focus on JUG and partnership between different agencies (e.g. Health Authorities; Local Authorities; Community Health Councils). However, this PhD research would suggest that it is also important to consider confluence in the *policy* stream within *and* across professional groups within a given agency (e.g. Health Board). That is, there was perceived to be considerable variation in the extent to which health care professionals prioritised smoking cessation, and incorporated it as a 'core' work activity, both within *and* across professional groups. This, in turn, impacted upon the *process* stream, whereby the need for commitment to smoking cessation by health professionals within and across professional groups often failed to be realised. For instance, difficulties in establishing links with the midwifery profession and in engaging GPs, was perceived to impact upon the development and delivery of local services.

This research would suggest that Exworthy & Powell's (2004) conceptual framework offers a useful means of interpreting the 'policy-action' process, in terms of how national policy can be implemented at the local level. Exworthy & Powell's (2004) research focussed on the issue of health inequalities, where joined-up government across central government bodies was paramount. However, within this case study it was more difficult to assess confluence in policy streams at the *central-central* level, given that the smoking cessation strategy required limited joined-up-government at the central level. However, the research clearly indicates that a lack of confluence in

the three policy streams across both vertical and horizontal (local-local) levels, was perceived to constrain the implementation of the smoking cessation strategy at the local level. Additionally, although Exworthy & Powell (2004) did not assign 'weight' or prominence to any one policy stream, this research would suggest that the *resource* stream was particularly crucial in mediating the policy-action process. That is, the funding allocated for the development of smoking cessation services (*resource* stream) fed into the *policy* stream, to render smoking cessation less of perceived priority at both the local and national level.



# CHAPTER TEN

## Conclusion and Implications

### 10.1. Conclusion

The findings from this research suggest that in reflecting upon the factors involved in the development, delivery and sustainability of a health promotion initiative within the primary care setting, it is important to consider the combined effect of both the setting (i.e. primary care), and the characteristics of the intervention itself (e.g. a health promotion initiative; funding; pharmacological interventions; targeting).

The research suggests that, as a health promotion strategy, smoking cessation faced traditional difficulties associated with the incorporation of health promotion practice within primary care. The introduction of Zyban (and NRT to a lesser extent) on prescription was, however, widely understood as a key catalyst in the development of services within primary care. As key gatekeepers to the implementation of strategies within the Practice setting, such engagement with GPs was perceived to be crucial in advancing the development of smoking cessation services within this setting.

Within LHCCs, local service development appeared to rely heavily on the interest, enthusiasm and commitment of several key staff members, who acted to drive local services forward. There were clear issues around professional roles and boundaries, and the perception of smoking cessation as a 'core' work activity and priority within the workload. The perceived inadequacies in funding available for sufficiently resourcing service delivery (e.g. staff time) appeared to fuel the debate around the ability of smoking cessation services to be embedded within core working practice.

Health visitors, practice nurses, other nursing staff, and pharmacists (in three LHCCs) played a key role in the delivery of intensive smoking cessation support. It

was clear from the interviews that smoking cessation was widely perceived to be an activity that was compatible with these health professionals' roles, and was an activity that could be accommodated within their work. As with much health promotion activity, however, GPs were perceived to be more ambivalent about their role in providing smoking cessation interventions. As a key part of the NHS smoking cessation strategy, however, it is crucial that GPs are engaged. This research highlighted potential factors underpinning the GP's role in providing brief interventions. These included (a) the tendency for GPs to operate within a secondary prevention framework, (b) the time involved in providing brief interventions, (c) awareness around the effectiveness of smoking cessation interventions and understandings of addiction, and (d) the applicability of guidelines within the context of patient consultations. However, this research only involved two GPs and one Clinical Director (previously a Lead GP), and therefore much more research is still required in order to establish the most effective ways in which to engage with this profession.

The findings from this research would suggest that if the recommendations to introduce dedicated 'smoking cessation specialists', as outlined by PATH (2003) come into effect, it should be done in a manner that does not overshadow the contribution of those staff currently offering smoking cessation support. In most cases, the initiation of local smoking cessation service development was underpinned by key motivated staff who were enthusiastic about smoking cessation work. However, the research found that there were varying levels of commitment to smoking cessation as a 'core' part of health professionals' workloads, and many staff were 'accommodating' it within their workload on a goodwill basis. For those staff who perceived it as an 'add-on' activity, there is the danger that with the introduction of dedicated staff, smoking cessation might come to be perceived as 'someone else's job'. In introducing dedicated staff, therefore, this research suggests that efforts should be made by local smoking cessation co-ordinators to reinforce the important role of those staff currently providing support.

A lack of progress in the development of services to meet the three target groups was underpinned by perceptions of the *suitability* (especially for targeting young people), and *capacity* of primary care. In terms of capacity, it was recognised that in order for services to effectively meet the needs of the three target groups, more sufficient funding would be required. In addition to considering the *setting* within which smoking cessation interventions are implemented, it is also important to consider the wider ethical/theoretical frameworks within which health professionals/staff operate. There were wider ethical debates around prioritising (a) women when they were pregnant (victim-blaming), and (b) the three target groups over 'ill' smokers. With regards to the latter, the placing of smoking cessation within a broader secondary prevention/CDM framework, was perhaps an inevitable consequence of the pressures/priorities facing staff within this setting. Discussions around low-income groups, were also couched within broader ethical and theoretical frameworks, particularly regarding the requirement for a broader approach to tobacco control. There were clearly different perceptions around the most effective strategies required to target low-income groups, which impacted upon the approaches (or lack of) developed within certain LHCCs. The development of high/low threshold services (i.e. motivational/no motivational assessment) also indicated that staff were operating within different models/approaches to reaching, not only low-income groups, but smokers more generally.

The updated smoking cessation guidelines for Scotland (Health Scotland and ASH Scotland, 2004) indicate that a range of different smoking cessation services have been established across Scotland. Some of these services are based outwith primary care, whilst others focus on targeting different groups. Given the variety in the types of services delivered, it may be useful for guidelines around 'best practice' to be issued to local services regarding these particular issues. The new monitoring system of Scottish services, may assist in establishing those approaches/models of service provision that are most effective in reaching a range of different populations of smokers. Additionally, as outlined previously, PATH is currently evaluating pilot interventions regarding the most effective ways to reach the three priority groups, which may add to this developing evidence-base. The findings of this research would

suggest, however, that in the implementation of future strategies, it will be important to consider the demands/priorities and capacity of the setting within which they are implemented, and the ethical/theoretical frameworks underpinning models of care/practice of staff within such settings.

At the time I conducted the fieldwork for this research, there was a high degree of frustration expressed by respondents around smoking cessation. That is, whilst there was enthusiasm for the smoking cessation strategy, perceived inadequacies in funding allocated, and a perceived lack of prioritisation of smoking cessation by The Scottish Executive were key sources of contention. This lack of prioritisation and funding of services was perceived to impact negatively on the ability of LHCCs to develop comprehensive and sustainable services. However, since the initiation of smoking cessation service development in 1999/2000, there have been significant changes regarding many aspects of the smoking cessation strategy in Scotland.

Smoking cessation, and tobacco issues more generally, have gained an increasing profile on the political agenda since the fieldwork was conducted in 2002/03. For instance, legislation which will ban smoking in public places has been passed, and there is an increased political and financial commitment to developing effective smoking cessation services as part of a wider national tobacco control action plan. Smoking cessation targets are being set for each Scottish Health Board, and a more structured system of monitoring Health Board services is in the process of being implemented Scotland-wide.

The longer-term funding commitment may go some way to addressing the staffing/resource problems experienced by local services, and concerns around service sustainability. Additionally, the increased priority assigned to smoking cessation, may also impact upon the perceptions of smoking cessation as an important, or 'core' issue to be tackled in primary care. The benefits of having a system of local co-ordination were clear from the experiences of various LHCCs. Therefore, the recommendation by PATH (2003) to introduce a more structured

system of service co-ordination is also likely to advance service development and delivery within Scottish Health Boards.

Although findings from this study suggest that these changes will have a significant impact on local service development, it is difficult to predict with certainty how smoking cessation service development in Scotland will progress. It is crucial that the over-arching financial commitment to services is reflected in local funding decisions and priorities. Indeed, the updated smoking cessation guidelines for Scotland (Health Scotland & ASH Scotland, 2004) have recommended that funding should be ring-fenced, at least until new services become embedded, although it remains to be seen whether this will happen in practice.

## **10.2. Research limitations**

The aim of this research was to contribute to an understanding of the process of smoking cessation service development within Scotland. However, the principal limitation of the research is that it involved a case study of only one Health Board region, which had developed services within the primary care setting. There are fifteen Health Boards in Scotland, each with different geographical/demographic make-ups. Additionally, there has been a variety of different types of smoking cessation services developed within these areas. It was outwith the remit of this research, to conduct an in-depth assessment and comparison of the services developed Scotland-wide. However, issues around the impact of funding on service development, staffing concerns/issues, monitoring/evaluation, and problems experienced in developing services to reach the three target groups, were key issues outlined in the evaluation of smoking cessation services in England, and by the mapping exercise of Scottish services conducted by PATH (2003). In reflecting upon the generalisability of the findings from this research, therefore, I would ascertain that many of the key findings may reflect the process of service development not only in Scotland, but also in the UK.

The second limitation of this study is that only one round of fieldwork was conducted. Since the time of initial fieldwork in 2002/early 2003, significant

developments have taken place that have increased the priority of smoking cessation within Scotland. Smoking cessation, and tobacco control more generally, is more firmly on the political agenda. The difficulties experienced in the early stages of service development, and the perceived low political priority assigned to smoking cessation, meant that many of the interviews had a negative tone. It would, therefore, have been interesting to conduct a second round of interviews in late 2003/04, in order to establish the impact of the new developments on local services. However, it was not possible to undertake this task within the time/resource limitations of the PhD.

The third limitation of this research is that only two GPs and one Clinical Director (previously a Lead GP) were interviewed in this study. I was keen to interview those people who had an overarching key role in service development/delivery within the LHCCs. Therefore, only those GPs who emerged as 'key players' were involved in the research. However, GPs played a central role in providing brief interventions, and a knowledge base is lacking around GPs' perceptions of/attitudes towards providing brief interventions. Although other health professionals/LHCC staff discussed the role of GPs in the smoking cessation intervention process, it would have been, in hindsight, beneficial to include the experiences of more GPs in this research.

### **10.3. Implications**

This research provides the first in-depth analysis of the development of smoking cessation services within a Scottish Health Board. In doing so, it has highlighted some of the key issues associated with the development and delivery of sustainable smoking cessation services within the primary care setting.

The findings of the research lend support to many of the recent recommendations and measures by The Scottish Executive that have witnessed the increased political priority and financial commitment assigned to the development of Scottish smoking cessation services. The research findings suggest that every effort should be made to ensure that the over-arching financial commitment to the development of Scottish services is followed-through, and reflected in, the development/delivery of local



smoking cessation services. This would help maintain the priority of smoking cessation at the 'local' level, and would facilitate the development of sustainable services in the longer term. The newly revised system of monitoring smoking cessation services, and setting targets for each Health Board, may help to increase the priority assigned to smoking cessation locally. However, in order to increase the potential priority assigned to reaching the three target groups, it may be worthwhile to consider setting Health Board targets for young people, low-income smokers, and pregnant women.

This research has highlighted that more effort is required to engage with GPs, and to improve the manner in which brief interventions are conducted. As a first port of call for many patients/smokers, this profession has a crucial role to play in the smoking cessation strategy. This research highlighted a range of potential factors influencing the provision of brief interventions by GPs. However, additional research should be conducted in order to establish the most effective ways to engage with this profession and improve the effectiveness of interventions.

It is encouraging that a range of pilot interventions are currently being evaluated across Scotland in order to establish the most effective ways of tackling smoking amongst various populations of smokers (including the three target groups). Combined with the information gathered from the new monitoring system to be implemented in Scotland, this may contribute to the development of 'best practice' models of providing smoking cessation services and other interventions to reduce smoking prevalence. In investigating alternative approaches to targeting smokers, this research suggests that it would be beneficial to take into account the characteristics of the setting/organisation within which interventions may be implemented (e.g. traditional 'ways of working'; demands/priorities; capacity), and the ethical and theoretical frameworks informing the interventions offered by service providers.

This research has shown that there is a wide range of health professionals within primary care who are enthusiastic about smoking cessation interventions, and have

demonstrated commitment to ensuring the implementation of local services. However, for those staff providing intensive smoking cessation support, perceptions of smoking cessation as a 'core' work activity varied. The recommendations for more structured co-ordination of local services is likely to address many of the service management issues experienced by LHCCs in this research. However, in the event that 'dedicated' smoking cessation specialists are introduced, it would be beneficial for Health Board co-ordinators to maintain a close link with such staff in order to facilitate training and encourage continued support from these health professionals. This may help to minimise the risk that smoking cessation essentially becomes a solely 'dedicated' service.

It is clear, however, that a state of considerable change exists for Scottish smoking cessation services. The climate for the development of services is substantially more positive than it was when I conducted the fieldwork for this research. In light of increased funding, potentially more effective co-ordination of local services, target-setting, improved monitoring, and a developing evidence-base around 'best practice', an exciting period lies ahead. Further research would provide a useful insight into how these changes, and new initiatives, impact upon the future development of local services.

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# Appendix One: Interview Guide (LHCC staff and Health Board Smoking Cessation Co-ordinators)

## Interviewee Background

1. What is your job within this LHCC/Locality, and what does it entail?
  - (background; length of time involved in smoking cessation).
2. How does the smoking cessation service fit within your role as...?

## Service Development

1. Could you describe the very early stages of service development (or impressions of, if weren't around)- from the allocation of the white paper money, to how the service initially became up-and-running?  
*(guidelines; local context and partnership history; any smoking cessation work going on beforehand; staffing- how were key staff identified; Funding; )*
2. How did the service develop from this initial starting point?  
*[strategic guidelines? (and from what source); staff; speed of service delivery; capacity]*
  - other reasons for the service being structured in this way?
3. Has the service specifically developed to meet local population needs in this LHCC, and if so, in what way?
  - identified 3 priority groups? (young people; low income; pregnant women). In what way, and what are the key issues around targeting?
4. (a) What have been the main (1) challenges, and (2) facilitating factors, facing service development in this LHCC/Locality?
  - changes in guidelines for the provision of NRT/Zyban
  - demographic factors
  - practical issues (i.e. staffing, training and funding)

(b) What was done to overcome any challenges? (and to what effect?)

(c) Has demand for the service changed over time (why / why not?)

### **Current Service and Service Delivery**

1. Could you outline the actual structure of the smoking cessation service that currently exists in this LHCC/Locality? (if not already answered by now)
  - any differences from the way it was before?
  - any differences in terms of people/health professionals involved?
  - is it stable, or still developing?
2. What are the key factors *facilitating* service delivery in this LHCC, and why? (staff; client group; LHCC working culture?)
3. What are the key *hindrances* to service delivery in this LHCC, and why? (and what is done to try and overcome these?)
4. How is smoking cessation perceived with regards to 'core' work?

### **Service Evaluation**

1. How does the Health Board's monitoring and evaluation process feed into service development and delivery?
2. Are there any procedures in place for monitoring and evaluating the service in this LHCC? (Local monitoring procedures)
3. What are your impressions and expectations regarding the monitoring and evaluation procedures that are currently in place? (funding; accountability; service improvement?)

### **Service Sustainability**

1. Based on your experience of the service so far, how do you see the smoking cessation service in this LHCC developing over the next year or beyond? (funding constraints?)
2. Is there anything that you anticipate would hinder or facilitate service development and sustainability?

### **Priority**

Where do you think smoking cessation sits as a priority at (a) the Health Board level, and (b) The Scottish Executive level? - *in relation to other health issues?*

## **Appendix Two: Interview Guide (Advisory Group)**

### **Background and Structure**

1. What was your role at the time, and how did you become involved in the Health Board's White Paper Advisory Group (*How/why were you approached?*)
2. What were your expectations of what the Advisory Group was going to achieve?
3. What was the precise role of the Advisory Group, and how did you fit into that?
4. Could you describe the organisational structure of the Advisory Group?  
(how often did it meet; formal/informal; how long did it last)

### **Steps and Decisions**

1. What initial steps were taken after the Advisory Group formed?  
(What was the content of initial/early discussions)
2. What was initially decided upon regarding how services should best be developed in the Health Board?
  - what factors were taken into account (funding; Health Board context)
  - what other types of issues were considered? 3 Priority Groups
  - any problematic issues?
3. How were decisions made about the best way forward?
  - was there any source of discontent? (if so, how was this resolved?)

### **Recommendations, Current Service Delivery and Development**

1. What is your understanding of how the recommendations of the Advisory Group were acted upon?
2. What are your impressions of how the smoking cessation services in the Health

Board are currently delivered?

-does it match expectations, and/or what the Advisory Group envisaged?

-perceived issues (positive/negative) around service development/delivery

3. How do you see the Health Board's/Scotland's smoking cessation strategy developing over the coming year (or beyond)?

-what do you perceive to be the key issues around service development, delivery and sustainability

## **Priority**

Where do you think smoking cessation sits as a priority at (a) the Health Board level, and (b) The Scottish Executive level? - *in relation to other health issues?*



# Appendix Three: Letter to LHCC General Managers

**Lucine Techer**  
PUBLIC HEALTH SCIENCES  
Department of Community Health Sciences  
University of Edinburgh  
Medical School  
Teviot Place  
Edinburgh  
EH8 9AG  
**Tel:** [REDACTED]  
**Email:** [ncine.Techer@ed.ac.uk](mailto:ncine.Techer@ed.ac.uk)

**Date**

**Name**  
**LHCC name**  
**Address**

**Dear [Name],**

My name is Lucine Techer and I am a PhD student in the Department of Community Health Sciences at the University of Edinburgh. I am writing to inform you about my research, in which I propose to interview some members of staff within [LHCC name].

The overall aim of my PhD is to explore the factors involved in the development of effective and sustainable smoking cessation services within NHS [Health Board area] since the allocation of the ‘Smoking Kills’ White Paper funding. Specifically, I wish to explore the factors that have been involved in the development, delivery and evaluation of the smoking cessation services within several LHCCs. My research is funded by the Chief Scientist’s Office at the Scottish Executive, who are interested in issues surrounding service development across NHS [Health Board area]. I would like to stress, however, that my PhD constitutes an independent piece of research conducted by the University of Edinburgh, and is not attributable to or associated with NHS [Health Board area] in any way.

My research will involve carrying out two rounds of interviews with approximately four/five key people within several LHCCs. The first round of interviews will commence within the next month, and the second round will be held approximately six months after the first round is completed. It is anticipated that the interviews will last no longer than one hour, and taking part would of course be on a voluntary basis. The interviews will be tape-recorded with the permission of the interviewees, and the recordings will be transcribed and analysed by myself. The only people who will have access to the transcripts will be myself and my supervisors within the University (Dr Amanda Amos and Dr Odette Parry). The interviews will remain confidential, and all names will be removed for anonymity purposes when writing up my thesis.

I am keen to talk to those people within [LHCC name] who can offer the best insights in to the issues surrounding the development, delivery, and/or evaluation of the smoking cessation service. As the [LHCC name] General Manager, I would therefore be grateful if you could suggest anyone within your Locality, including yourself, whom you feel it would be useful for me to interview.

I have enclosed an information sheet outlining the purpose of my PhD in more detail. If you would like the opportunity to discuss my research with me in greater depth, then I would be happy to meet with you. I will telephone in a few days time to answer any queries which you might have about my research and I look forward to speaking with you then.

**Yours sincerely**

**Lucine Técher**

## **Appendix Four:** Letter to Health Board staff, and members of the Advisory Group for the Health Board's Tobacco White Paper Programme.

**Lucine Techer**  
PUBLIC HEALTH SCIENCES  
Department of Community Health Sciences  
University of Edinburgh  
Medical School  
Teviot Place  
Edinburgh  
EH8 9AG  
**Tel:** [REDACTED]  
**Email:** [REDACTED] [Lucine.Techer@ed.ac.uk](mailto:Lucine.Techer@ed.ac.uk)

**Date**

**Name**

**Job title**

**Address**

**Dear [Name]**

My name is Lucine Techer and I am a PhD student in the Department of Community Health Sciences at the University of Edinburgh. I am writing to tell you about my PhD and to ask if you would be willing to participate in my research.

I am currently entering the second year of my PhD research, the overall aim of which is to explore the factors involved in the development of effective and sustainable smoking cessation services within NHS [Health Board area] since the allocation of the 'Smoking Kills' White Paper funding. Specifically, I wish to explore the factors that have been involved in the development, delivery and evaluation of the smoking cessation services within several LHCCs. My research is funded by the Chief Scientist's Office at the Scottish Executive, who are interested in learning about the experience of service development across NHS [Health Board area]. I would like to stress that my PhD constitutes an independent piece of research conducted by the University of Edinburgh, and is not attributable to or associated with NHS [Health Board area] in any way.

My research is qualitative in nature, and I will carry out interviews with approximately four/five key people within several LHCCs, as well as with a range of other key stakeholders/interested parties. These interviews will commence within the next month. A further round of interviews with the same interviewees will be held approximately six months after the first interview takes place. The purpose of this second interview will mainly be to explore the issue of service sustainability, as well as other issues that may arise from the first round of interviews.

Given your role as smoking cessation co-ordinator/that you were a member of the Advisory Group for the [Health Board] Tobacco White Paper Programme, it would be really useful to hear your point of view on the issues that I outlined previously. In particular, it would be interesting to hear about the factors involved in the early stages of service development, and also your impressions of how the services have developed since that time.

It is anticipated that the interviews will last no longer than one hour, and taking part would of course be on a voluntary basis. The interviews will be tape-recorded with the permission of the interviewees, and the recordings will be transcribed and analysed by myself. The only people who will have access to the transcripts will be myself and my supervisors within the University (Dr Amanda Amos and Dr Odette Parry). The interviews will remain confidential, and all names will be removed for anonymity purposes when writing up my thesis.

Your participation in my research would be greatly appreciated, and I hope that you will agree to take part. I will telephone in a few days time to find out if you would like to be interviewed, and to arrange a suitable time for meeting. I have enclosed an information sheet outlining the purpose of my research in more detail. However, if you require any additional information in the meantime, then please contact me.

**Yours sincerely,**

**Lucine Técher**

## Appendix Five: Letter to key LHCC Contacts

**Lucine Techer**  
PUBLIC HEALTH SCIENCES  
Department of Community Health Sciences  
University of Edinburgh  
Medical School  
Teviot Place  
Edinburgh  
EH8 9AG  
Tel: [REDACTED]  
Email: [ecine.Techer@ed.ac.uk](mailto:ecine.Techer@ed.ac.uk)

**Date**

**Name**  
**Job title**  
**Address**

**Dear [Name],**

My name is Lucine Techer and I am a PhD student in the Department of Community Health Sciences at the University of Edinburgh. I am writing to tell you about my PhD and to ask if you would be willing to participate in my research.

I am currently entering the second year of my PhD research, the overall aim of which is to explore the factors involved in the development of effective and sustainable smoking cessation services within NHS [Health Board area] since the allocation of the 'Smoking Kills' White Paper funding. Specifically, I wish to explore the factors that have been involved in the development, delivery and evaluation of the smoking cessation services within several LHCCs. My research is funded by the Chief Scientist's Office at the Scottish Executive, who are interested in learning about the experience of service development across NHS [Health Board area]. I would like to stress that my PhD constitutes an independent piece of research conducted by the University of Edinburgh, and is not attributable to or associated with NHS [Health Board area] in any way.

My research is qualitative in nature, and I will carry out interviews with approximately four/five key people within several LHCCs. These interviews will commence within the next month. A further round of interviews with the same interviewees will be held approximately six months after the first interview takes place. The purpose of this second interview will be to explore the issue of service sustainability.

The [General Manager/Development Manager/Public Health Practitioner] of your LHCC, [Name], informed me of your close involvement with the smoking cessation service in [LHCC name], and of your active role in providing smoking cessation support. Given your level of involvement in the service, it would be really useful to hear your point of view on the issues that I outlined previously.

Taking part in the interviews would of course be on a voluntary basis, with the understanding that your involvement could be terminated at any time. It is anticipated that the interviews would last no longer than one hour. The interviews will be tape-recorded with your permission, and the recordings will be transcribed and analysed by myself. The only people who will have access to the transcripts will be myself and my supervisors within the University (Dr Amanda Amos and Dr Odette Parry). Your interviews will be confidential, and all names will be removed for anonymity purposes when writing up my thesis.

Your participation in my research would be greatly appreciated, and I hope that you will agree to take part. I will telephone in a few days time to find out if you would like to be interviewed, and to arrange a suitable time for meeting. I have enclosed an information sheet outlining the purpose of my research in more detail. However, if you require any additional information in the meantime, then please contact me.

**Yours sincerely,**

**Lucine Técher**



## **Appendix Six:** Information Sheet (accompanying letters in Appendices three, four, and five)

The development of the smoking cessation services within one Health Board region since the 'Smoking Kills' White Paper, provides an excellent opportunity to explore in great depth the factors involved in the development of effective and sustainable health promotion practice in a Primary Care setting in Scotland. Through a series of in-depth interviews with some of the key people who have been involved in the development, delivery and/or evaluation of the smoking cessation service within NHS [Health Board], the study aims to provide a comprehensive picture of the factors and processes involved in these particular aspects of service delivery. By conducting interviews within several LHCCs, it is intended that the study will be informed by a broad range of experiences within NHS [Health Board] as a whole.

The study involves in-depth interviews with 4/5 key people within several LHCCs in [Health Board area]. For anonymity purposes, the names of these LHCCs, and the people interviewed, will remain confidential in any of the study outputs. The specific aims of these interviews will be to establish the following:

1. What smoking cessation services have been developed and delivered by each of these LHCCs?
2. How are these services evaluated in each of the LHCCs, and what are the prominent issues surrounding the evaluation process?
3. What are the key factors that have influenced the development, delivery, and evaluation of the smoking cessation services within each LHCC?
4. What are the implications for, and the issues surrounding, the long-term sustainability of these services?

The study will involve two rounds of interviews with the same interviewees. The first round will commence within the next month, and will concentrate on research questions 1-3. These interviews will be transcribed and analysed before a second round of interviews is carried out approximately six months after the first round is completed. This second interview will deal primarily with the issue of service sustainability (research question 4), as well as other issues that may arise from the analysis of the first round of interviews.

## Appendix Seven: Consent Form

The interview in which you are about to take part forms part of my PhD research that I am conducting at the University of Edinburgh. The aim of this research is to explore the factors that have been involved in the development, delivery and evaluation of the smoking cessation services in NHS [Health Board] since the allocation of the 'Smoking Kills' White Paper funding. The purpose of this interview is to hear your point of view regarding these issues. I would like to stress that this PhD constitutes an independent piece of research conducted by the University of Edinburgh, and it therefore not attributable to, or associated with NHS [Health Board] in any way. Please read the following information before signing below.

---

### **I agree to participate in this interview and understand that:**

- My interview will last approximately one hour
- Participation is on a voluntary basis, and I am therefore free to end the interview at any time I wish.
- The interview will be tape-recorded with my permission. The recording will be transcribed and analysed by Lucine Techer. The recording and the transcript will remain confidential, and the only people who will have access to the transcript will be Lucine Techer and her two supervisors within the University (Dr Amanda Amos and Dr Odette Parry). All recordings will be destroyed upon completion of the research.
- The data from this interview will be used to form the basis of a PhD, although any quotations used will be anonymised. Therefore, my name, and the name of my LHCC will not be linked with the quotations used in any of the PhD outputs (e.g. Thesis; Journal publications).
- If I have any queries about this interview or the research at any stage, then I can contact Lucine Techer at: [Lucine.Techer@ed.ac.uk](mailto:Lucine.Techer@ed.ac.uk) (Tel: 0131 650 3038)

---

NAME (Print) \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Appendix Eight: Final Coding Framework

## Commitment

- 1.1.Core vs Additional:** smoking cessation as a core/additional part of health professionals' workload (with particular reference to personal interest/commitment/professional role)
- 1.2.Key people-Motivators:** role of key people/health professionals/co-ordinators in driving forward local service development and/or delivery.
- 1.3.Goodwill:** smoking cessation support being carried out on a goodwill/unfunded basis.
- 1.4.Priority-Interest:** smoking cessation support, or the role of co-ordinators, being undertaken due to a personal interest in smoking, and/or smoking being identified as a personal priority

## Interventions

- 2.1.Professional Roles:** reference to professional roles (and suitability of) in the provision of smoking cessation support.
- 2.2.Stages of Change/Motivational Approach:** interventions/service delivery or smoking/addiction based on the Stages of Change model. Discussions around patient motivation and service delivery.
- 2.3.Maintenance Strategy:** a broader motivational approach; offering interventions post-6 weeks to maintain cessation (maintenance strategy).
- 2.4.Smokers/Addiction:** reference to the addiction process and the role of smoking within the contexts of people's lives.
- 2.5.Prioritisation:** attitudes towards prioritisation. (ethical/theoretical)
- 2.6.Appropriateness of primary care:** compatibility of the primary care setting with the targeting of the three priority groups, and the development of smoking cessation services more generally.

## Strategy

- 3.1.Central-local relations:** relationship between LHCCs and the Health Board, and role in the development of local smoking cessation services.
- 3.2.Priority-agenda-investment:** reference to the perceived priority of smoking cessation, with regards where smoking sat in relation to other health strategies/issues.
- 3.3.Training:** issues around the training of health professionals in providing smoking cessation support.
- 3.4.Funding:**
  - 3.4.1. Service development/recurring:** discussion of the funding allocated for the development of smoking cessation services (inc. recurring nature of the funding); impact of funding on service development/delivery decisions.

- 3.4.2. **Core vs Additional:** smoking cessation as a core/additional part of health professionals' workload (with particular reference to *funding*)
- 3.4.3. **Priority:** where smoking cessation was perceived to sit as a smoking cessation strategy, in relation to funding allocations.
- 3.4.4. **Staff time/resources:** discussion of funding in relation to the staff time and resources required for development/delivery of local smoking cessation services.

### 3.5.Evaluation:

- 3.5.1. **Value of feedback:** perceived value of the monitoring data/feedback that LHCCs received from the Health Board
- 3.5.2. **Effort-return:** effort put into conducting the follow-ups, completing the monitoring forms; perceptions of the Health Board 'treatment' of the monitoring data.
- 3.5.3. **Service Provision:** the potential application of the Health Board evaluation/monitoring as a form of smoking cessation intervention (e.g. for relapse)
- 3.5.4. **Time-consuming:** reference to the time involved in conducting the follow-up procedures.
- 3.5.5. **Informal:** following patients up informally after their six weeks of support; encouraging patients from groups to meet informally as a form of peer support.

3.6.**Dedicated Staff:** discussion around 'dedicated' resource/smoking cessation support workers, including when this related to the issue of smoking cessation and 'core' work.

### 3.7.Targeting:

- 3.7.1. **Skill utilisation/multi-disciplinary:** discussion of the role of different health professions in the targeting of the three priority groups.
- 3.7.2. **Circumstantial:** targeting taking place on a 'passive' basis (i.e. recruiting from a 'convenient' pool of smokers).
- 3.7.3. **Demand:** demand for smoking cessation services from the target groups.
- 3.7.4. **Funding:** impact of funding on the development of services to meet the needs of the three target groups.
- 3.7.5. **Action:** discussion around services/approaches adopted to meet the needs of the three target groups.

## LHCC Capacity

- 4.1.**Existing structure/ 'ways of working':** the impact/influence of LHCCs' existing ways of working on the development of local smoking cessation services. Reference to Practice ethos/ways of working for individual GP practices in LHCCs
- 4.2.**LHCC Demographics:** impact of LHCCs' geographic/demographic make-up on service development/delivery
- 4.3.**Priority/agenda/investment:** the priority assigned to smoking cessation at the local LHCC level.

- 4.4.Planning/co-ordination:** local (LHCC) systems of co-ordinating smoking cessation services; issues around co-ordinating services; administrative/ clerical support.
- 4.5.Demand-led/meeting demand:** discussion around the demand-led nature of smoking cessation service development (particularly regarding Zyban), and how services developed in an effort to meet to demand.
- 4.6.Practical resources/considerations:** the practical resources of providing group/one-to-one support and practice-based/centralised smoking cessation support. (e.g. finding premises; co-ordinating referrals)
- 4.7.Availability/Access/Flexibility:** issues around the development of accessible and flexible smoking cessation services to meet patients needs (inc. motivational) within the LHCCs.

## Amalgamation

The following outlines the key amalgamation of sub-categories/themes that took place in the process of organising and writing the four data chapters.

- (a) **1.1. (core vs additonal) & 3.4.2. (core vs additional)**

**Sub-category/theme:** *Core vs Additional*  
**Conceptual Category:** *Commitment*

- (b) **2.1. (Professional roles).** This sub-category/theme was incorporated within the Conceptual Category '*Commitment*'. This altered the focus of this Conceptual Category from personal interest/commitment, to personal and professional interest/commitment.

- (c) **3.7.1; 3.7.2; 3.7.3 (Targeting) & 2.6. (Appropriateness of primary care)**

**Sub-category/theme:** *Appropriateness of primary care*  
**Conceptual Cateogory:** *Interventions*

- (d) **2.2. (Stages of Change/motivational approach); 2.3. (Maintenance Strategy) & 4.7. (Availability/Access/Flexibility).**

**Sub-category/theme:** *Motivational Approach*  
**Conceptual Category:** *Interventions*

## Appendix Nine: Funding sources for Scottish Smoking Cessation Services

**Table 4. Funding sources for Scottish smoking cessation services**

	<i>Smoking Kills White Paper*</i>	<b>Health Improvement Fund (HIF) *</b>	<b>Breath of Fresh Air for Scotland**</b>	<b>New Forthcoming Funding (No Smoking Day)***</b>	<i><b>TOTAL</b></i>
<b>1999/00</b>	1m	0	0	0	<b>1m</b>
<b>2000/01</b>	1m	0	0	0	1m
<b>2001/02</b>	1m	1m	0	0	2m
<b>2002/03</b> <i>(Fieldwork)</i>	1m	1m	0	0	2m
<b>2003/04</b>	1m	1m	1m	0	3m
<b>2004/05</b>	1m	1m	1m	0	3m
<b>2005/06</b>	1m	1m	5m	0	7m
<b>2006/07</b>	1m	1m	5m	2m	9m
<b>2007/08</b>	1m	1m	5m	4m	<b>11m</b>

\* This funding was incorporated within Health Boards' Unified Budgets

\*\* A Breath of Fresh Air for Scotland: Improving Scotland's Health: The Challenge. Tobacco Control Action Plan (*The Scottish Executive, 2004*)

\*\*\* This new forthcoming funding was announced by the First Minister in March 2005

**Source:** A copy of this table was provided by The Tobacco Control Division (Substance Misuse Division) at The Scottish Executive Health Department.